Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address: Dr Richard Taylor 1920 South Loop 256 Palestine, TX 75801	MDR Tracking No.: M4-05-6459-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: SORM RepB ox # 45	Date of Injury: Employer's Name: State Of Texas Insurance Carrier's No.: WC2279834

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor states the documentation submitted does support the level of service billed.

Principle Documentation:

1. Requestor's position statement
2. TWCC-60
3. CMS-1500
4. EOB's

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The respondent maintains it's denial of charges being insufficiently documented.

Principle Documentation: 1. TWCC-60 Response

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	Denial Code	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
05/20/04	01, N3	99214	1	$00.00
07/05/04	105,N,0	99214	2	$00.00
07/05/04	73,D	99080	3	$00.00
TOTAL DUE				$00.00

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Section 413.011(a-d) titled (Guidelines and Medical Policies), and Commission Rule 134.202 titled Medical Fee Guideline effective August 1, 2003 set out reimbursement guidelines.

1. CPT Code 99214 for date of service 05/20/05 denied with "O" – "Denial after reconsideration " , "N3" –"Not appropriately documented. Per Rule 134.202(b) the documentation submitted does not support the level of service billed. Therefore reimbursement is not recommended.
2. CPT Code 99214 for date of service 07/05/04 denied with "105"- "Additional documentation needed to review charges", "N" - "Not appropriately documented", "O" – "Denial after reconsideration". Per Rule 134.202(b) the documentation submitted does not support the level of service billed. Therefore reimbursement is not recommended.
3. CPT Code 99080 for date of service 07/05/04 was listed on the table of disputed services; however the requestor indicated payment was received. Therefore this CPT code will not be reviewed by MDR.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.202

PART VII: DIVISION DECISION AND ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the Division has determined that the requestor **is not** entitled to additional reimbursement **.**

Ordered by:

Authorized Signature	Typed Name	05/05/2006 Date of Order

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005]. An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. The Division is not considered a party to the appeal.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.