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.: M4-05-6496-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: AMERICAN HOME ASSURANCE CO Rep Box #19	Date of Injury: Employer's Name: WAL MART STORES INC Insurance Carrier's No.: C3261099

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

POSITION SUMMARY: "…Dr Rosenstein examined the patient's lumbar myelogram…and made a medical decision in regards to his condition based on this examination…"

Principle Documentation:

1. DWC-60
2. Office note
3. EOB's
4. CMS 1500

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

POSITION SUMMARY: "…This carrier disagrees with the requester that all the key components necessary to bill a 99214 level office visit were documented…"

Principle Documentation:

1. DWC-60
2. CPT Assistant
3. Office note

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)
3/26/03	YO, TG, YF	99214	1	$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 Division Rule §134.202 titled (Medical Fee Guideline For Medical Treatments and Services Provided Under the Texas Worker's Compensation Act) effective August 1, 2002, sets out reimbursement guidelines.

1. Code 99214 for date of service 3/26/03 was denied for "TG – Documentation does not support the service billed. Carriers may not reimburse the service at another billing codes value per rule 133.301 (B). A revised CPT code or documentation to support the service billed may be submitted" and "YF – Reduced or denied in accordance with the appropriate fee guideline ground rue and/or maximum allowable reimbursement (MAR) and "YO – Reimbursement was reduced or denied after reconsideration of treatment/service rendered". The documentation submitted by the Requestor does not meet the required criteria for the level of service billed, as it does not contain a detailed examination and decision making of a moderate complexity as required per MFG E/M GR IV (C) (2) and the CPT descriptor. Therefore, no reimbursement is recommended for this date of service in dispute.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.201
Texas Labor Code Sec. §413.031
28 Texas Administrative Code Sec. §134.1

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.

Decision by:

	James Schneider	9/29/06
Authorized Signature	Typed Name	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.