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

Requestors Name and Address: Debbie Crawford, D.O. 3804 Highway 377 South Brownwood, Texas 76801	MDR Tracking No.: M4-05-9783-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: American Home Assurance Company Rep Box # 19	Date of Injury: Employer's Name: Wal-Mart Stores, Inc. Insurance Carrier's No.: C4271287

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Requestor's Position Summary as indicated on the Table of Disputed Services states, "Request for reconsideration, no record acknowledged. Time spent justifies a 99214 as documented."

Principle Documentation:
1. DWC 60 package
2. CMS 1500s
3. EOBs
4. Medical Records

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Respondent's Position Summary states in part, "…no further payment was recommended towards the amount in dispute..."

Principle Documentation:
1. Response to DWC 60

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)
11/18/04	N, 271	99214	1-2	$96.91
TOTAL DUE				$96.91

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) effective August 1, 2003, sets out reimbursement guidelines.

1. This dispute relates to CPT code 99214 for date of service 11/18/04 and was denied as "N—Not documented and 271—Potential code changes: documentation does not support billed code. Please return bill & EOR with documentation to support this charge".

2. The Respondent reimbursed the Requestor $00.00. The CPT code descriptor for 99214 requires at least two of these three key components: detailed history, detailed examination, medical decision making of moderate complexity, 25 minutes face-to-face with the patient. The documentation submitted supports the level of service billed, which included the detailed exam and medical decision making of moderate complexity. Therefore, per Rule 134.202(c)(1), reimbursement in the amount of $96.91 ($77.53 x 125%) is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code, Section §413.011(a-d)
28 Texas Administrative Code Sec. §134.1
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 entitled to reimbursement in the amount of $96.91 plus all accrued interest due at the time of payment to the Requestor within 30-days of receipt of this Order.

Ordered by:

Authorized Signature	Typed Name	Date of Order
		11/30/06

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.