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: Richard Taylor, D.O. 1920 South Loop 256 Palestine, Texas 75801	MDR Tracking No.: M4-05-9911-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: /American Home Assurance Company C/o Flahive Ogden & Latson Rep Box # 19	Date of Injury: Employer's Name: Wal Mart Stores, Inc. Insurance Carrier's No.: C2292050

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

"Claim denied times two for lack of documentation. The documentation that is attached shows that we meet 2 of the 3 key components that are required per the Medical Coding Guidelines."

Principle Documentation:
1. Requestor's position summary
2. TWCC 60/Table of Disputed Services
3. CMS 1500
4. Explanation of Benefits
5. Report dated 09/29/04

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

"…N—Not Documented…"

Principle Documentation:
1. Respondent's position summary
2. TWCC 60/Table of Disputed Services
3. CMS 1500
4. Explanation of Benefits
5. Report dated 09/29/04

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)
09/29/04	N	99214	1	$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 Commission Rule 134.202 titled (Medical Fee Guideline) effective August 1, 2003, set out reimbursement guidelines.

1. Code 99214 for date of service 09/29/04 denied as "N—Not documented". Carrier reimbursed the Requestor $00.00. The Requestor submitted medical records to substantiate the level of service billed. Per Rule 134.202, reimbursement shall be according to Medicare plus 125%. Medicare pricing is $96.91 ($77.53 x 125% = $96.91). Therefore, reimbursement in the amount of $96.91 is recommended.

Therefore, it is the conclusion of the Medical Review Division that reimbursement in the amount of $96.91 is due the requestor.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.201
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**. The Division hereby **ORDERS** the insurance carrier to remit this amount 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	01/27/06 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.