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: Stephen de Young, M.D. 16659 SW Freeway, Suite 321 Sugar Land, Texas 77479	MDR Tracking No.: M4-07-0228-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Wausau Business Insurance Company Box 28	Date of Injury: Employer's Name: New ICM LP, A Texas Limited Par Insurance Carrier's No.: 197637707

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary per the Table of Disputed Services: "Office service and charge reasonable and documented in medical records."

Principle Documentation:

1. DWC-60/Table of Disputed Service/Summary Position
2. CMS-1500's
3. EOB's

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: "We base our payments on the Texas Fee Guidelines and the Texas Workers' Compensation Commission Act and Rules."

Principle Documentation:

1. DWC-60/Table of Disputed Service/Summary Position
2. CMS-1500
3. EOBs

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)
09/08/05	X901 X124	CPT code 99215	1 and 2	$115.04
Total				$115.04

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. Respondent denied services for CPT code 99215 as, "X901-Documentation does not support level of service billed. X124-Payment for this charge is not recommended without medical records."

2. The Requestor submitted medical records and documentation supporting at least two of the three components, comprehensive history and comprehensive examination per rule 134.202. Therefore, the MAR is $142.75 ($114.20 x 125% = $142.75); however, the Requestor indicated the amount of $115.04 is less than the MAR listed on the Table of Disputed Services. Therefore, reimbursement in the amount of $115.04 is recommended per Rule 134.202(d)(2).

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Labor Code Sec.§ 413.031
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 $115.04.** The Division hereby ORDERS the Respondent to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30 days receipt of this Order.

Ordered by:

	Michael Bucklin	11/15/06
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.