



MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: <input checked="" type="checkbox"/> Health Care Provider <input type="checkbox"/> Injured Employee <input type="checkbox"/> Insurance Carrier	
Requestor's Name and Address: Dr. Jeffrey D. Reuben 4126 Southwest Freeway, Suite 700 Houston, Texas 77027	MDR Tracking No.: M4-07-0300-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Liberty Mutual Fire Insurance Company Box 28	Date of Injury:
	Employer's Name: Weiser Security Services, Inc.
	Insurance Carrier's No.: 973431712

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: "The carrier refuses to reimburse procedure 99215. The Division of Workers Compensation states that in order to bill the aforementioned CPT code, the following must be included in the medical documentation: a comprehensive history; a comprehensive examination; and/or medical decision making of high complexity. Two of the three components are well documented and included in the documentation."

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. EOB's

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)
04/12/06	X901, X598	CPT code 99215	1 and 2	\$153.51
Total				\$153.51

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. X598-Claim has been re-evaluated based on additional documentation submitted; no additional due."
2. Documentation supports at least two of the three components, comprehensive history and comprehensive examination per rule 134.202. Therefore, reimbursement in the amount of \$153.51 is recommended. ($\$122.81 \times 125\% = \153.51)

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 \$153.51**. 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.