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: Jacob Rosenstein, MD 800 W. Arbrook Blvd., #150 Arlington, TX 76015	MDR Tracking No.: M4-07-0662-01 Claim No.: Injured Employee's Name:
Respondent's Name: Insurance Co. of the State of PA Rep. Box # 19	Date of Injury: Employer's Name: AMR Corp. Insurance Carrier's No.: 56600540C

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary as listed on the Table of Disputed Services: "Documentation does support this level of service – 99214."

Principle Documentation: 1. DWC 60 package
2. CMS 1500's
3. Explanation of Benefits (EOBs)
4. Medical Reports

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary

None submitted

Principle Documentation: 1. DWC 60 package

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)
5-8-06	150, W1	99214	1-6	$102.69
TOTAL DUE				$102.69

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 procedure/service that was billed under CPT code 99214 that was denied/reduced reimbursement by the insurance carrier based upon: "150 – Payment adjusted as info submitted does not support this level of service. Documentation does not justify level of service. Resubmit using code for appropriate lower level of service; W1 – WC State Fee Schedule adjustment. Reimbursement for your resubmitted invoice has been considered. No additional monies are being paid at this time.

2. Per Commissioner's Bulletin #B-0006-06, "The CY 2005 conversion factor of $37.8975 is to be used effective immediately when calculating MAR for services provided on or after January 1, 2006."

3. Per Rule 133.307(d), the request for medical dispute resolution was received in the Division on 9-27-06.

4. Based on Division Rule 133.307(d)(1-2), the only date of service eligible for review is 5-8-06.

5. CPT code 99214 is defined as "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family." The office visit report supports level of service billed per Rule 134.202, reimbursement is recommended.

6. Per CMS-1500, the zip code 76015 is located in Tarrant County. The MFG MAR for CPT code 99214 in Tarrant County is $102.69, this amount is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 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 additional reimbursement in the amount of **$102.69.** 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:

	Elizabeth Pickle, RHIA	January 5, 2007
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.