Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Jacob Rosenstein, M.D. 800 W. Arbrook Blvd. # 150 Arlington, TX 76015	MFDR Tracking #: M4-07-1422-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: Liberty Mutual Fire Insurance Rep Box # 28	Date of Injury: Employer Name: Southern Tank Transport Inc. Insurance Carrier #: 973447656

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: The Respondent did not submit a position summary but the Table of Disputed Services Rationale states "…Documentation supports the level of service billed…"

Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)
3. EOB(s)

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: States in part "…The documentation reflects a problem focused history and exam. No past family or social history or comprehensive review of systems is documented. All three of the components must meet or exceed level requirements…"

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Review of the box 32 on CMS-1500, revealed zip code 75015 is located in Dallas county.

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
07/26/2006	X901	99214	1-2	$00.00
Total Due:				$00.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Section §413.011(a-d) titled, *Reimbursement Policies and Guidelines*, and Division Rule 134.202 titled, *Medical Fee Guideline* effective August 1, 2003, sets out the reimbursement guidelines.

Per Rule 133.307 (d) (1) date of service 07/26/2006 was timely filed and is eligible for review.

1. These services were denied by the Respondent with reason code "X901-Documentation does not support the level of service billed".

2. The CPT code descriptor for procedure code 99214 requires two of these three components: detailed history, detailed examination, medical decision making of moderate complexity. The Requestor submitted documentation to support a detailed exam but did not support the medical decision making of moderate complexity or the detailed history.

Therefore per Rule 134.202(d), reimbursement is not recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.1, §134.202
28 Texas Administrative Code Sec. §134.202(d)

PART VII: DIVISION DECISION

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 not entitled to reimbursement for the services involved in this dispute

DECISION :

06/21/2007

Authorized Signature	Medical Fee Dispute Resolution Officer	Date

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.