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

Type of Requestor: (x) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address: Victor L. Lyday, M.D. 1303 McCullough, Suite 361 San Antonio, Texas 78212	MDR Tracking No.: M4-07-3481-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: INDEMNITY INSURANCE CO. OF NORTH AMERICA REP BOX #: 15	Date of Injury: Employer's Name: Family Dollar Stores., Inc. Insurance Carrier's No.: 6450183649

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Requestor's Position Summary states in part, "According to Medicare CCI edits, CPT code 99204-25 is not global to any other CPT code billed for this DOS. This was the patient's initial visit in which a significant amount of time (approximately 45 minutes) was spent going over patient's history, physical examination and discussion of treatment options. Despite 3 attempts for reconsideration with the last request sent via Certified Mail, the carrier has not responded to our attempts for reconsideration."

Principle Documentation: 1. DWC 60 package
2. CMS 1500s
3. EOBs
4. Medical Records

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Respondent did not submit a response to the DWC 60.

Principle Documentation: 1. N/A

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)
07/10/06	42	99204-25	1	$147.04
TOTAL DUE				$147.04

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. This dispute relates to CPT code 99204-25 for date of service 07/10/06 that was denied with reason code "42—Charges exceed our fee schedule or maximum allowable amount…Significant, separately identifiable E/M service by the same physician on the day of a procedure. Service/visit falls within the follow-up period of a surgery." The Requestor billed with modifier -25 indicating that this service was a significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service. According to the 2002 Medical Fee Guideline, CPT code 99204-25 is not considered a component procedure to any other procedures billed on the same date of service. Therefore, per Rule 134.202 (b) and (c)(1), reimbursement in the amount of $147.04 ($130.14 x 125%) is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code, Section §413.011(a-d)
28 Texas Administrative Code Sec. §133.307 (effective 12/31/06)
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. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of **$147.04** plus accrued interest, due within 30 days of receipt of this Order.

Ordered by:

Signature	Medical Dispute Resolution Officer	04/13/07 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.