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: Robert E. Urrea, M.D. 6211 Edgemere, Suite 1 El Paso, TX 79925	MFDR Tracking #: M4-07-4623-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: Texas Mutual Insurance Co. Rep Box # 54	Date of Injury: Employer Name: Caldarellas Antiques Inc. Insurance Carrier #: 99D0000357483

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: The Requestor's position summary states "…We feel the attached documentation does support a 99214 office visit…"

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: "…At present Texas Mutual is maintaining its position that the documentation of the E&M 99214 visit of 10/02/2006 more actually reflects 99213…"

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Review of the box 32 on CMS-1500, revealed zip code 79925 is located in El Paso county.

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
10/02/06	150,W4,890,891	99214	1-2	$97.01
Total Due:				$97.01

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 (c)(1) (A) date of service 10/02/2006 was timely filed and is eligible for review.

1. These services were denied by the Respondent with reason code "150-Payment adjusted because the payer deems the information submitted does not support this level of service", "W4- No additional reimbursement allowed after review of appeal/reconsideration", "890-This level of service is being disputed as it does not meet the components as defined in the CPT book", "891- The insurance company is reducing or denying payment after reconsideration".

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 documentation submitted by the Requestor does meet the level of service billed. There was a detailed examination, medical decision making of moderate complexity documented. Therefore per Rule 134.202 reimbursement in the amount of $97.01 ($77.61 x 125%) is 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. §133.307

PART VII: DIVISION 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 **$97.01** plus accrued interest, due within 30 days of receipt of this Order.

ORDER:

05/31/2007

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.