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:	MFDR Tracking #: M4-07-5453-01
US Healthworks Medical Group of Texas 3440 Preston Ridge Rd. Building 4 Suite 250 Alpharetta, GA 30005	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: Texas Mutual Insurance Rep Box # 54	Date of Injury:
	Employer Name: Brazos Presbyterian Homes Inc.
	Insurance Carrier #: 99G0000444430

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary states in part "…We review 100 percent of our clinical documentation prior to billing. Our coding staff assigns the appropriate CPT code(s) for all services provided based upon the clinical documentation contained in the medical record. This clinical documentation is attached to each claim that we submit for payment…"

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 "…Since the claimant's health history has not been documented as reviewed, the documentation of this E & M level of service is incomplete. As such Texas Mutual cannot issue payment for a service not properly documented…"

Principle Documentation:

1. DWC-60 Response

PART IV: SUMMARY OF FINDINGS

Review of the box 32 on CMS-1500, revealed zip code 77054 is located in Harris county.

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
04/26/2006	150,W4,890,891	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 (c)(1) (A) date of service 04/26/2006 was timely filed and is eligible for review.

1. The service was denied by the Respondent with reason codes "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 only supports a detailed examination. Therefore per Rule 134.202 (c)(1) 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. §133.307

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 :

05/25/2007

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.