**Texas Department of Insurance, Division of Workers' Compensation**
Medical Fee Dispute Resolution, MS-48
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:<br><br>US Healthworks Medical Group of Texas<br>3440 Preston Ridge Rd Building 4 Ste 250<br>Alpharetta, GA 30005 | MFDR Tracking #: M4-07-5579-01<br>DWC Claim #:<br>Injured Employee: |
| Respondent Name and Box #:<br><br>Texas Mutual Insurance Company<br>Box #: 54 | Date of Injury:<br>Employer Name: ALL TEXAS TEMPS INC<br>Insurance Carrier #: 99G0000450272 |

## PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

The Requestor has not submitted a Position Summary; however, the Requestor's rationale on the Table of Disputed Services states, "E/M level is coded appropriately – See attached documentation."

Principle Documentation:

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

## PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "The requestor reports using the AMA's 1995 E&M Documentation Guidance as a basis for determining which level of E&M service to code for the disputed date of service. Those same guidelines indicate that for an extended E&M service, i.e. code 99214, an extended review of systems must be documented. The requestor's documentation reflects the examining physician did document a review of the claimant's health history but does not document when that review was done as required by the 1995 E&M Documentation Guidelines. Since the claimant's health history has not been documented as reviewed, the documentation of this E&M level of service is incomplete."

Principle Documentation:

1. Response to DWC 60

## PART IV: SUMMARY OF FINDINGS

| Date(s) of Service | Denial Code(s) | CPT Code(s) and Calculations | Part V Reference | Amount Due |
|---|---|---|---|---|
| 06/08/06 | 150, 890 | 99214 | 1-3 | $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, set out the reimbursement guidelines.

1. This dispute relates to CPT code 99214 and Respondent's denial based upon denial reasons:

   - "150 – Payment adjusted because the payer deems the information submitted does not support this level of service.
   - 890 – This level of service is being disputed as it does not meet the-components as defined in the CPT book."

2. The Respondent's response indicates that the Requestor did not submit a request for reconsideration prior to requesting a Medical Dispute Resolution. The Requestor was contacted on July 3, 2007 and again on July 25, 2007 regarding proof of request for reconsideration. The Requestor did not submit proof that a request of reconsideration was submitted to the Respondent.

3. Per Rule 134.202(b), 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."

4. Per Rule 133.210, documentation submitted does not support the level of service billed; therefore, reimbursement is not recommended.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES**

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §133.210, §134.1, §134.202

**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:**

| | | 07/31/07 |
|---|---|---|
| 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.**