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: US Healthworks Medical Group of Texas 3440 Preston Ridge Rd Building 4 Ste 250 Alpharetta, GA 30005	MFDR Tracking #: M4-07-5671-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: Texas Mutual Insurance Company Box #: 54	Date of Injury: Employer Name: Stillmeadow Inc Insurance Carrier #: 99G0000453347

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "…USHW's position is that the clinical documentation we submit with each claim to the carrier supports the level of E/M code billed…"

Principle Documentation:

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

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "It is this carrier's position that a comprehensive history, comprehensive examination and medical decision making of high complexity, is not appropriately documented. For instance, the requestor did not document , what activities improved or worsened the patient's complaints. What are the patient's limitations? What therapy has worked and what therapy has not worked, etc. The medical decision making was not high in complexity, in fact, the medical decision making was to continue with current medications and physical therapy as scheduled. As indicated in this carrier's denial the patient's condition and diagnosis did not support the need for this level of service, the highest level office visit for an established patient. The requestor did not document medical decision making of high complexity. It is this carrier's position that what appears to be a routine follow up examination does not require medical decision making of the highest complexity as it is suggested by the use of the highest level established patient examination code 99215. It appears the injured worker was simply in the office for a follow up visit and medical management for the identified and diagnosed problem. At present, Texas Mutual is maintaining its position that the documentation provided for the E&M 99215 visit of 6/13/06 billed does not meet the components as defined in the CPT book for a 99215…"

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
6/20/06	150, 890, 891, W4	99215	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 99215 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.
   - 891 – The insurance company is reducing or denying payment after-reconsideration.
   - W4 – No additional reimbursement allowed after review of appeal/reconsideration."

2. Per Rule 134.202(b), CPT code 99215 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 comprehensive history; a comprehensive examination; medical decision making of high 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 40 minutes face-to-face with the patient and/or family."

3. 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. §134.1, §134.202, §133.210

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:

	Scott Hansen	6/28/07
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.