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 #: M4-07-5727-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: Texas Mutual Insurance Company Box #: 54	Date of Injury: Employer Name: TRAMONTINA USA INC Insurance Carrier #: 99G0000465068

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
09/29/06	150, 18, W4, 878, 890, 891	99214	1-4	$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.
   - 18 – Duplicate claim/service.
   - 890 – This level of service is being disputed as it does not meet the components as defined in the CPT book.
   - 878 – Duplicate appeal. Request medical dispute resolution through DWC for continued disagreement of original appeal decision.
   - 891 – The insurance company is reducing or denying payment after-reconsideration.
   - W4 – No additional reimbursement allowed after review of appeal/reconsideration."

2. The Respondent did not respond to the Division with documentation to support their denial "18 -Duplicate claim/service, 878 – Duplicate appeal. Request medical dispute resolution through DWC for continued disagreement of original appeal decision."

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:

		07/09/07
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.