MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes ( ) No
Requestor's Name and Address Dr. Pedro Nosnik 4100 West 15th St., Ste. 206 Plano, TX 75093	MDR Tracking No.: M4-05-6516-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 54 Texas Mutual Insurance Co. 221 W. 6th St., Ste. 300 Austin, TX 78749	Date of Injury: Employer's Name: Award Moving Services Inc. Insurance Carrier's No.: 99D0000351440

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
12/20/04	12/20/04	99372	$46.00	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

The Requestor did not submit a Position Summary; however, the Requestor's rationale on the table of disputed services states, "Ins carrier is stating this is global, this is a few issue."

PART IV: RESPONDENT'S POSITION SUMMARY

It is this carrier's position that no reimbursement was due for code 99372 based the bundled status assigned to code 99372… Medicare does not reimburse for code 99372 as it is a bundled code.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- CPT Code 99372 for date of service 12/20/04 denied as "G". Per Rule 134.202(b) TWCC system participants shall apply the Medicare program for coding, billing, reporting and reimbursement of professional medical services. Research of Medicare policy 100-4,12,30.6.16 reveals that telephone calls (codes 99371 through 99373) may not be paid separately. Payment for telephone calls is included in payment for billable services (e.g., visit, surgery, diagnostic procedure results). Therefore, reimbursement is not recommended.

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to (additional) reimbursement.

Ordered by:

Authorized Signature	Typed Name	Date of Order
	Marguerite Foster	May 26, 2005

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____