



MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) Health Care Provider () Injured Employee () Insurance Carrier

Requestor's Name and Address:

John A. Sazy M.D.
 431 Omega Drive #104
 Arlington, TX 76014

MDR Tracking No.: M4-05-A819-01

Claim No.:

Injured Employee's Name:

Respondent's Name and Address:

Twin City Fire Insurance Company
 Rep Box # 27

Date of Injury:

Employer's Name: Import Export Management Services

Insurance Carrier's No.: 857C 05717

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor states that the documentation meets all guidelines.

Principle Documentation:

1. Requestor's position statement
2. TWCC-60
3. EOB's
4. HCFA's

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor did not submit a position summary.

Principle Documentation: 1. N/A

PART IV: SUMMARY OF DISPUTE AND FINDINGS

| Date(s) of Service | Denial Code | CPT Code(s) or Description | Part V Reference | Additional Amount Due (if any) |
|--------------------|-------------|----------------------------|------------------|--------------------------------|
| 12/16/04 | O | 99214 | 1 | \$00.00 |
| TOTAL DUE | | | | \$00.00 |

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

Section 413.011(a-d) titled (Guidelines and Medical Policies), and Commission Rule 134.202 titled Medical Fee Guideline effective August 1, 2003 set out reimbursement guidelines.

1. CPT Code 99214 denied with O. Code was denied on initial EOB as "N" (not appropriately documented). Per Rule 134.202 the documentation submitted does not support the level of service billed. Therefore reimbursement is not recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.201
28 Texas Administrative Code Sec. §134.202

PART VII: DIVISION DECISION AND ORDER

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 additional reimbursement.

Ordered by:

02/17/06

Authorized Signature

Typed Name

Date of Order

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.