Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

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, MD 431 Omega Drive, Suite 104 Arlington, Texas 76014	MDR Tracking No.: M4-05-B801-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Connecticut Indemnity Company Box 11	Date of Injury: Employer's Name: HAC Corp Insurance Carrier's No.: 790053983800

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary per the Table of Disputed Services: "There was no other service for this particular day & this is not a bundled code. Dr. Sazy spent 15-25 minutes on the phone with physician from Ins. Co. discussing her care for surgery. Ins. Co. needs to pay for this."

Principle Documentation:

1. DWC-60/Table of Disputed Service/Summary Position
2. CMS-1500's
3. EOB's

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

No response received from the Respondent.

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)
01/06/05	W1 (AB)	CPT code 99371	1, 2 and 3	$15.00
Total				$15.00

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

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

1. Respondent denied these services as "W1- (AB)-The payment for this service is always bundled into payment for other services."

2. Per Rule 134.202(e)(3), services were rendered per the submitted letter indicating a conference call was made to another physician discussing the claimant's care for surgery.

3. Per Rule 134.202 (c)(6); the carrier did not assign a relative value unit and did not dispute the amount billed, therefore, reimbursement is recommended in the amount of $15.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Labor Code Sec.§ 413.031
28 Texas Administrative Code Sec. §134.1
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** entitled to reimbursement **in the amount of $15.00.** The Division hereby ORDERS the Respondent to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30 days receipt of this Order.

Ordered by:

	Michael Bucklin	10/31/06
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.