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, M.D. 431 Omega Drive, Suite 104 Arlington, Texas 76014	MDR Tracking No.: M4-05-B808-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Tarrant County C/o Harris & Harris Rep Box # 42	Date of Injury: Employer's Name: Tarrant County Insurance Carrier's No.: TC100701

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

"TWCC Fee Guideline awards pmt for physician to physician peer conversation re. pt. Ins. Co. has not bothered to respond to our appeal."

Principle Documentation:

1. Requestor's position summary
2. TWCC 60/Table of Disputed Services
3. CMS 1500
4. Explanation of Benefits

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

"…Respondent has reviewed the Provider's information, and is in the process of re-evaluating the bills made the basis for this dispute…"

Principle Documentation:

5. Respondent's position summary

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)
08/30/04	N	99371 (Telephone Conference, Medical Management)	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. Code 99371 for date of service 08/30/04 was denied "N—Not documented. Please submit documentation supporting charges". Rule 134.202(c)(6) states, "for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assigned a relative value, which may be based on nationally recognized published relative studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments." The Requestor billed the Respondent $25.00 for CPT code 99371. Carrier failed to assign a relative value unit and reimbursed the Requestor $00.00. The Requestor did not submit medical documentation to substantiate 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. §134.202

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 reimbursement.

Ordered by:

Authorized Signature	Typed Name	05/17/06 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.