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: Star Anesthesia 45 N. E. Loop 410 # 900 San Antonio, TX 78216	MDR Tracking No.: M4-07-0029-01 Claim No.: Injured Employee's Name:
Respondent's Name: Indemnity Insurance Co. Rep Box # 15	Date of Injury: Employer's Name: Boeing Co. Insurance Carrier's No.: 4650232159

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary states in part, "…An error was made in your calculation of the contracted allowable fee…"

Principle Documentation: 1. DWC 60 package
2. CMS 1500's
3. EOBs

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent signed for their copy of the dispute on 09/06/2006, but they did not submit a response.

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)
01/17/06	W1,W4	01400-AA	1-2	$24.09
TOTAL DUE				$24.09

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.

The request for medical dispute in this case was received 08/28/06.

1. The Requestor stated in their position that "…An error was made in the calculation of the contracted allowable fee…" The Respondent made a total payment of $473.30 with reduction codes of "W1-Workers Compensation State Fee Schedule Adjustment", & "W4-No additional reimbursement allowed after review of appeal/reconsideration". Modifier "AA" indicates the service was personally performed by the anesthesiologist. Payment for the service is calculated as follows:

- Time Units = 97 minutes divided by 15 =6.5 units
- Base Units = 4 units
- 6.5 + 4 = 10.50 units
- 10.50 units x $47.37 (conversion factor) = $ 497.39

2. Therefore, since the Respondent made a payment of $473.30, the Requestor is due an additional reimbursement of $24.09.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code Sec. 413.011(a-d)
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 additional reimbursement in the amount of **$24.09**. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30-days of receipt of this Order.

Ordered by:

		11/09/2006
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.