

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: <input checked="" type="checkbox"/> HCP <input type="checkbox"/> IE <input type="checkbox"/> IC	Response Timely Filed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Requestor's Name and Address MTR Management 112 W. Pipeline Road #13 Hurst, Texas 76053	MDR Tracking No.: M5-05-1813-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address American Protection Insurance, Bx 42	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
7-12-04	7-23-04	CPT code 97799CP	\$4,800.00	\$4,800.00

PART III: REQUESTOR'S POSITION SUMMARY

On 6-7-05 the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

In accordance with Rule 134.600 (h) (4), the requestor provided a copy of the preauthorization letter dated July 7, 2004. . The carrier denied these sessions for unnecessary medical treatment based on a peer review. Rule 133.301 (a) "the insurance carrier shall not retrospectively review the medical necessity of a medical bill for treatments (s) and/or service (s) for which the health care provider has obtained preauthorization under Chapter 134 of this title." Therefore, reimbursement is recommended in the amount of \$4,800.00 in accordance with Rule 134.600 (b)(1)(B).

Regarding CPT code 99199 on 7-13-04, 7-16-04 and 7-23-04: Per Rule 134.6 Reimbursement for travel for the injured worker is not handled in the Medical Review Division, but in the local field office.

PART IV: RESPONDENT'S POSITION SUMMARY

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

PART VI: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of \$4,800.00. 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 20-days of receipt of this Order.

Findings and Decision:

_____	Donna Auby	6-21-05
Ordered by:	_____	_____
_____	Margaret Q. Ojeda	6-21-05
Authorized Signature	Typed Name	Date of Order

PART VII: 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 ___19_____. 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 en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

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

Signature of Insurance Carrier: _____ Date: _____