



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:

**Buena Vista Workskills
5445 La Sierra #204
Dallas TX 75231**

MDR Tracking No.: M5-05-1968-01

Claim No.:

Injured Worker's Name:

Respondent's Name and Address:

Transportation Insurance Co. Rep Box # 47

Date of Injury:

Employer's Name:

Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documentation: 1. Requestor's position statement - Preauthorization obtained for chronic pain management program and individual psychotherapy.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documentation: 1. Letter dated 4-4-05 states that requestor has not met prerequisites for medical dispute resolution and that the disputed services are directly related to pending extent of injury issues.

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)
3-18-04	F	97799-CP-CA	1	\$62.50
3-25-04 to 4-1-04	S	97799-CP-CA, 90806	2	-0-
3-30-04	S	97799-CP-CA	3	\$175.00
TOTAL DUE				\$237.50

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

- Carrier's EOB and financial detail screen indicates \$500.00 paid plus interest. Requestor billed 4.5 hours @ \$125.00 per hour = \$562.50; therefore, recommend additional reimbursement of \$62.50.
- Carrier submitted copy of check #103096049 for \$3,918.00 to cover dates of service 3-25-04 (\$875.00), 3-26-04 (\$875.00), 3-31-04 (\$875.00), 4-1-04 (\$875.00), 4-13-04 (\$118.00) and 5-27-04 (FCE for \$300.00 which is not on the table of disputed services; however, this reimbursement is included in this check amount); therefore, no dispute exists.
- Carrier's EOB and financial detail screen indicates \$700.00 paid plus interest. Requestor billed 7 hours @ \$125.00 per hour = \$875.00; therefore, recommend additional reimbursement of \$175.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec.§ 413.011(a-d) and Sec. §134.1

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 \$237.50.**

Ordered by:

Dee Z Torres

3-13-06

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.