THIS DECISION HAS BEEN APPEALED. THE FOLLOWING
IS THE RELATED SOAH DECISION NUMBER: 453-05-8829.M5

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP ( ) IE ( ) IC	**Response Timely Filed?** ( ) Yes (X) No
Requestor=s Name and Address Buena Vista Workskills 5445 La Sierra Dr #204 Dallas, Texas 75231	MDR Tracking No.: M5-05-2124-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Atlantic Mutual Insurance Company, Box 19	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
4-9-04	4-21-04	CPT code 97799 CPCA	$3,597.30	$3,597.30

PART III: REQUESTOR'S POSITION SUMMARY

In accordance with Rule 134.600 (h) (4), the requestor provided a copy of the preauthorization letter dated 11-18-03. The carrier denied dates of service 4-12-04 through 4-21-04 for unnecessary medical treatment on the original audits in May, 2004. Rule 133.301 (a) states "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." The carrier made a partial payment and denied the services as "F – Fee Guideline MAR reduction" on the audits of March, 2005.

PART IV: RESPONDENT'S POSITION SUMMARY

The carrier has made partial payment on these services.

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

Per Rule 134.202(e)(5)(E) reimbursement for CARF accredited Programs shall be $125.00 per hour. Additional reimbursement is recommended in the amount of $3,597.30 in accordance with Rule 134.600 (b)(1)(B).

PART VI: DETAIL FINDINGS (If needed)

PART VII: 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 $3,597.30. 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 by:

	Donna Auby	06/22/05
Ordered By:		
	Margaret Ojeda	06/22/05
Authorized Signature	Typed Name	Date of Order

PART VIII: 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 _____. 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 in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

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

Signature of Insurance Carrier: _____ Date: _____