

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP () IE () IC	Response Timely Filed? (X) Yes () No
Requestor's Name and Address SICEM 3103 Eisenhower Rd. #K-14 San Antonio, TX 78209	MDR Tracking No.: M5-05-2264-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Great American 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			
4-19-04	6-4-04	97112	\$160.40	\$160.40
4-19-04	6-4-04	97140	\$144.10	\$144.10
4-19-04	6-4-04	97150	\$41.24	\$41.24
4-19-04	6-4-04	97113	\$101.01	\$101.01
4-19-04	6-4-04	97110	\$773.00	\$0

PART III: REQUESTOR'S POSITION SUMMARY

The EOB's show that the carrier has allowed reimbursement for some services. The requestor states that he has made numerous attempts to obtain a breakdown of the services paid by the carrier. The carrier only denies the services as "D-Duplicate" with no breakdown of the services which were reimbursed. The requestor has withdrawn date of service 6-28-04.

PART IV: RESPONDENT'S POSITION SUMMARY

In a letter dated 5-6-05 the carrier denied the services as "Duplicative" with no additional information. The carrier does state that they paid CPT code 97110 for date of service 6-28-04.

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

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 \$446.75. 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.

Ordered by:

6-7-05

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 Order 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 and Order was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision and Order 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 and Order should be attached to the request.

The party appealing the Division's Decision and Order 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 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: _____