

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 Central Dallas Rehab Brandy 3710 Rawlins, Suite 1400 Dallas, TX 75219	MDR Tracking No.: M5-05-2327-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Box 39	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			
12-26-03 12-30-03 1-13-04	12-26-03 12-30-03 1-13-04	CPT code 99212 (no EOB was submitted)	\$141.69	\$141.69
1-6-04 2-19-04 2-23-04	1-6-04 2-19-04 2-23-04	CPT code 99212 (denied with "G")	\$145.21	\$145.21
12-26-03 12-30-03 1-13-04 2-23-04	12-26-03 30-03 13-04 2-23-04	CPT code 97110 (no EOB was submitted or service was denied with "F")	\$488.45	0
2-19-04	2-19-04	CPT code 97530 (denied with "F")	\$150.31	\$150.31

PART III: REQUESTOR'S POSITION SUMMARY

In a letter dated June 23, 2005 the requestor withdrew dates of service which were denied for medical necessity.

PART IV: RESPONDENT'S POSITION SUMMARY

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

The dispute contains unresolved medical fee issues only. The Division shall proceed to resolve the medical fee dispute in accordance with Rule 133.307.

Regarding services for which there were no EOB's: The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's per rule 133.307(e)(3)(B).

Regarding CPT code 99212 denied with "G": Per Medicare fee guidelines this is not a bundled service.

Regarding CPT code 97110: Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy

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: _____