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 Work Ready Rehab 500 Century Plaza Drive #165 Houston, Texas 77073	MDR Tracking No.: M5-05-2534-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Texas Mutual Insurance Company, Box 54	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			
5-17-04	6-2-04	CPT code 97110-GP	$1,444.56	0
6-2-04	6-2-04	CPT code 97002-59	$50.00	$50.00

PART III: REQUESTOR'S POSITION SUMMARY

The requestor withdrew date of service 6-3-04 and it will not be a part of this dispute.

PART IV: RESPONDENT'S POSITION SUMMARY

The services were denied as "The insurance company is reducing or denying payment after reconsidering a bill."

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

Regarding CPT code 97110-GP: 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 and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. **Reimbursement not recommended.**

CPT code 97002-59 was denied as "The insurance company is reducing or denying payment after reconsidering a bill." However, the carrier did not reimburse a partial amount or state a reason for not doing so. **Recommend reimbursement in accordance with 134.202.**

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
						Total Left Column:	$0.00
						Total Amount Due:	$0.00

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 $50.00. 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.

Ordered by:

Authorized Signature	Typed Name	6-22-05 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: _____