



MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: <input checked="" type="checkbox"/> Health Care Provider <input type="checkbox"/> Injured Employee <input type="checkbox"/> Insurance Carrier	
Requestor's Name and Address:	MDR Tracking No.: M5-05-2977-01
REHAB AFFILIATES 9150 HUEBNER ROAD SUITE 340 SAN ANTONIO TX 78240	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: TEXAS MUTUAL INSURANCE BOX 54	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documentation submitted: TWCC-60 package, EOBs, CMS 1500s.

Position summary: Documentation supports length of treatment for each therapy session... The plan of care was established and progressed as patient progressed. The services are supported and medically necessary for this patient's severity of injury.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documentation submitted: TWCC-60 response and EOBs.

Position summary: The requester billed \$2,830.00; Texas Mutual paid \$1,728.83. The requester believes it is entitled to an additional \$769.77.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
2-3-05	97002-59-25	(1)	-0-
2-3-05	97112	(2)	\$ 30.82

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

The medical necessity issues were dismissed on 9-15-05 due to nonpayment of the IRO fee.

- (1) Neither party submitted an EOB. The requestor did not submit convincing evidence of request for EOB per rule 133.308; therefore no review and no reimbursement recommended. Note, modifier -25 is invalid for this code.
- (2) Requestor billed two units and the carrier paid for one unit. Carrier denied as '790, charge was reduced per the Texas Medical Fee Guideline.' This code is reimbursable for more than one unit; therefore, recommend reimbursement as requested.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 134.202(e)(3) and 133.308

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 \$30.82. 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 30 days of receipt of this Order.

Ordered by:

Medical Dispute Officer

9-28-05

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.