Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address:	MDR Tracking No.: M5-06-0816-01
Integra Specialty Group, P.A. 517 North Carrier Parkway, Suite G Grand Prairie, Texas 75050	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: American Casualty Company of Reading Rep Box # 47	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: DWC-60
POSITION SUMMARY: Per the table of disputed services "treated compensable injury area".

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60
POSITION SUMMARY: None submitted by Respondent

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
12-30-04	96004 ($152.75 MAR - $94.43 payment)	(1)	$58.32
01-26-05	96004 ($152.75 billed <MAR - $94.43 payment)	(1)	$58.32
01-03-05 to 01-12-05	97110 (3 units @ $108.42 MAR X 5 DOS – $353.25 payment)	(1)	$188.85
01-03-05 & 01-12-05	99213 ($68.24 billed < MAR X 2 DOS - $66.08 payment)	(1)	$70.40
01-05-05	97032 (2 units @ $40.40 billed < MAR - $27.36 payment)	(1)	$13.04
01-12-05	97140 ($34.13 billed < MAR - $22.34 payment)	(1)	$11.79
	TOTAL		$400.72

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

(1) The carrier denied the service with denial code R (extent of injury) which has been resolved. The carrier made payment, however, the payment made did not satisfy the MAR or the amount billed by the Requestor for the service in dispute. Additional reimbursement is recommended as listed above, which is either the balance of the MAR or the balance of the amount billed after the carrier payment.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 134.202

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 $400.72. 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:

		06-02-06
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.