



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: Buena Vista Workskills 5445 La Sierra Dr #204 Dallas TX 75231	MDR Tracking No.: M5-06-0982-01
	Claim No.:
	Injured Worker's Name:
Respondent's Name and Address: Commerce & Industry Insurance Rep Box # 19	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documentation: 1. Requestor's position statement – insurance company paid 16 days out of 20 days. It is our position that the carrier has established an unfair and unreasonable time frame in paying for the services that were medically necessary and rendered to the injured worker.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documentation: 1. The carrier disputes that the provider has shown that the treatment underlying the charges was medically reasonable and necessary. The carrier asserts that it has paid according the applicable fee guidelines. Further, the documentation provided does not establish medical necessity.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	Denial Code	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
4-4-05	1, charge exceeds fee schedule	97545-WH-CA	1	\$32.00
8-23-05		97799-CP-CA		\$ 6.25
TOTAL DUE				\$38.25

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

- On 3-29-06, the Requestor submitted an updated table of disputed services. All disputed services have been paid except for a portion as noted above. The Requestor submitted proof of CARF accreditation; therefore, recommend the additional amounts.
- The carrier will be billed for inappropriate reimbursement per rule 134.202(e)(5)(C) and (e)(5)(E).

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. § 413.011(a-d)
 28 Texas Administrative Code Sec. §134.1, 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 \$38.25.**

Ordered by:

3-29-06

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.