MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes ( ) No
Requestor's Name and Address Integra Specialty Group, P.A. 517 North Carrier Parkway, Suite G Grand Prairie, Texas 75050	MDR Tracking No.: M4-05-1009-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Arch Insurance Company P O Box 819045 Dallas, Texas 75381 Box #19	Date of Injury: Employer's Name: Insurance Carrier's No.: TXW0002526001

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			
10/30/03	**11/17/03**	**97799**	**$6,300.00**	**$-0-**

PART III: REQUESTOR'S POSITION SUMMARY

A position statement was not submitted by the Requestor; however, the rationale taken from the "Table of Disputed Services" states, "PA#PH065679N/Per MAR Guidelines".

PART IV: RESPONDENT'S POSITION SUMMARY

The Respondent's position statement states in part, "…Please note that the Respondent made an additional payment of $6,300.00 on 9/29/04. …I also find that interest is owed. …Attached are copies of the checks supporting payment…"

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

The Respondent has included payment information that included copies of checks; check number CQ 19175 dated 9/29/04 in the amount of $6,300.00 and check number CQ 19435 dated 10/13/04 in the amount of $11.52. Additional reimbursement is not recommended.

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 not entitled to additional reimbursement.

Ordered by:

Authorized Signature	Typed Name	April 6, 2005 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: _____