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 Southwest Center Medical 7125 Marvin D. Love #107 Dallas, TX 75237	MDR Tracking No.: M4-05-1828-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Royal Indemnity Co. c/o Cunningham Lindsey US Inc. P.O. Box 9008 Addison, TX 75001 BOX 11	Date of Injury: Employer's Name: Insurance Carrier's No.: 290044943600

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			
03/30/04	**03/30/04**	**CPT Code 99213**	**$6.26**	**$6.26**

PART III: REQUESTOR'S POSITION SUMMARY

Position Summary dated 10/27/04 states in part, "Our charges were not paid according to 2004 TWCC/Medicare MFG. We requested for econsideration via certified mail.."

PART IV: RESPONDENT'S POSITION SUMMARY

Position Summary not submitted.

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

- CPT Code 99213 for date of service 03/30/04. Per Rule 134.202(b) and (c)(1) the amount to be reimbursed for the office visit is $68.24; the insurance carrier paid $61.98 leaving a balance of $6.26. The health care provider was contacted and no additional payment was made; therefore, additional reimbursement in the amount of $6.26 is recommended.

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 $6.26. 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:

	Marguerite Foster	02-28-05
Authorized Signature	Typed Name	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: ________________________