MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC

Response Timely Filed? (x) Yes ( ) No

Requestor's Name and Address
Pain Solutions
6806 AVE I
Houston, TX 77011

MDR Tracking No.: M4-05-2157-01

TWCC No.:

Injured Employee's Name:

Respondent's Name and Address BOX #: 19
Valiant Insurance Co.
C/o Flahive, Ogden & Latson

Date of Injury:

Employer's Name: Brazos River Constructors, Inc.

Insurance Carrier's No.: 2720017845

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			
01/05/04	02/13/04	97799-CP (18 DOS)	$14,400.00	$14,400.00

PART III: REQUESTOR'S POSITION SUMMARY

Position Summary not submitted.

PART IV: RESPONDENT'S POSITION SUMMARY

Carrier asserts that these services were neither reasonable nor necessary to treat the ___, compensable injury. It also does not appear that these services were preauthorized as required by TAC 134.600.

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

The Requestor withdrew dates of service 12/09/03 through 12/29/03; therefore, these dates of service will not be included in this findings and decision.

- CPT Code 97799-CP for dates of service 01/05/04 through 02/13/04 denied as "U – Unnecessary Treatment (without peer review). Per Rule 134.600(h)(10)(B) the Requestor obtained preauthorization for the dates of service in dispute. Certification Numbers are: 031218-000749 and 031218-000749-001. Per Rule 133.301(a) an insurance carrier cannot retrospectively deny services for which preauthorization has been obtained. Per Rule 134.202(e)(5)(E)(i-ii) reimbursement in the amount of $14,400.00 (18 dates of service x 8 hours = 144 hrs. x $100/hr) 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 $14,400.00. 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:

	Amy Rich	July 25, 2005
Authorized Signature	Typed Name	Date of Order

Findings & Decision by:

	Marguerite Foster	July 25, 2005
Authorized Signature	Typed Name	Date of Decision

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: ________________________