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 John D. Carlson, D.C. 6905 West Gate Blvd., Ste. A Austin TX 78745	MDR Tracking No.: M4-05-5953-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 43 City of Austin PO Box 559006 Austin TX 78755	Date of Injury: Employer's Name: City of Austin Insurance Carrier's No.: A092-03-00017

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			
4/7/04	**4/7/04**	**99455-WP**	**$300.00**	**$300.00**
4/7/04	**4/7/04**	**99455-V4**	**$70.00**	**$0.00**

PART III: REQUESTOR'S POSITION SUMMARY

3/21/05: Requestor seeking full reimbursement for services (MMI/ WBIR) rendered on 4/7/04.

PART IV: RESPONDENT'S POSITION SUMMARY

6/9/05: As of this date, a response has not been received from the Respondent.

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

- The TWCC-60 request was received by MDR on 3/31/05 seeking additional reimbursement for DOS 4/7/04.
- The narrative report of the impairment evaluation attached to the TWCC-69 gave a 0% Whole Body Impairment Rating (WBIR). Proper reimbursement is determined by all the documentation including this report that an examination/evaluation was performed. According to the Advisory 2004-01, the carrier must read the report describing the calculation of the IR in order to determine which method was used to assign the IR and to reimburse the health care provider appropriately.
- CPT code 99455-V4 and 99454-WP were billed for DOS 4/7/04. The attached "Impairment Rating Report," that accompanied the TWCC-60 form, included History, Examination, Impression/Diagnoses, Whole Body Impairment %, Discussion of Findings and attached worksheet. According to Rule 134.202 (e)(6)(B)(iii) the doctor billed accordingly: (e)(6)(C)(i)(II), modifier applicable, (e)(9)(R) designating whole procedure, and (e)(6)(D)(iii) for the cost of the services. Therefore additional reimbursement is recommended.

  CPT 99455-V4 – Billed: $70.00

  Denied 'C- per negotiated contract." Reimbursement of $63.00 was submitted. Per review, neither party submitted contract information, therefore no further reimbursement can be recommended.

  CPT 99455-WP –Billed: $300.00

  Denied 'F'-Fee Schedule MAR Reduction." Reimbursement of $0.00. Per MAR for musculoskeletal body area is $350.00 however, requestor billed $300, therefore, reimbursement in the amount of **$300** is recommended

PART VI: 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 **$300.00**. 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.

Authorized Signature	Name	6 / 14 / 05 Date of Order

PART V: 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, PO 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: _____