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 Andrew B. Small, III, MD, FACS PO Box 1404 Decatur TX 76234	MDR Tracking No.: M4-05-8176-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 10 Universal Underwriters of TX c/o Mr. Melvin Banks Fax #: 281/ 866-9566	Date of Injury: Employer's Name: PAACO Automotive Group, LP Insurance Carrier's No.: 2330031253

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**			
5/14/04	**6/4/04**	**99244, 99213, 99214**	**$394.55**	**$394.55**

PART III: REQUESTOR'S POSITION SUMMARY

4/25/05: "There have been denials on multiple dates of service that are not consistent with TWCC guidelines and/or the services provided, therefore, we ask for your assistance…We have not received any EOB's for multiple DOS. We have sent the request for reconsideration via fax / certified mail to ensure receipt of the medical bill and are enclosing proof of that submission…"

6/5/05: "Enclosed is the additional information requested for the MDR dispute…"

PART IV: RESPONDENT'S POSITION SUMMARY

No response received as of this date.

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

- On 4/28/05, MDR received the Requestor's request for reimbursement of treatment/services rendered from 5/14/04 through 6/4/04 to the injured worker.
- The Requestor provided convincing evidence that the HCFA's were submitted for reimbursement and reconsideration to the Respondent according to 133.304(k).
- According to 133.304 (c) and (l), the Respondent did not provide explanation of non-reimbursement to allow the Requestor to understand the reason for the reduction or lack of payment, therefore the dispute will be reviewed accordingly for fee issues.
- After review of the information received, SOAP notes support services rendered as billed. Reimbursement is recommended according to Rule 134.202, Medicare program payment policies / methodologies:

DOS: 5/14/04 CPT 99244 MAR: $220.01
DOS: 5/28/04 CPT 99213 MAR: $ 68.24
DOS: 6/4/04 CPT 99214 MAR: 106.36
TOTAL DUE: **$394.55**

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 $394.55. 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.

		6 / 27 / 05
Authorized Signature	Name	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: ________________________