Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address: Rehab 2112 P. O. Box 671342 Dallas, Texas 75267-1342	MDR Tracking No.: M4-05-9394-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Ace American Insurance Company C/o Ace USA/ESIS Rep Box # 15	Date of Injury: Employer's Name: Racetrac Petroleum, Inc. Insurance Carrier's No.: 00108900876WC01

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

"Impairment rating not paid according to TWCC guidelines, should received $150.00 for the impairment rating evaluation and $45.00 for the MMI evaluation."

Principle Documentation:
1. Requestor's position summary
2. TWCC 60/Table of Disputed Services
3. CMS 1500
4. Explanation of Benefits
5. TWCC-69 and Report of MMI/IR Evaluation dated 12/16/04

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Respondent did not submit a response.

Principle Documentation:
1. N/A

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	Denial Code	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
12/03/04	M	99455-WP-V3	1	$29.25
TOTAL DUE				$29.25

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

Section 413.011(a-d) titled (Guidelines and Medical Policies), and Commission Rule 134.202 titled (Medical Fee Guideline) effective August 1, 2003, set out reimbursement guidelines.

1. Code 99455-WP0V3 for date of service 12/03/04 was denied as "M—Payment Recommend at Fair and Reasonable rate". Carrier reimbursed the Requestor $165.75. The Requestor submitted the TWCC-69 and MMI/IR report dated 12/03/04. Per Rule 134.202(e)(6)(C)(i)(1) and and (D)(II)(a), the submitted MMI/IR report supports services were rendered as billed. Therefore, additional reimbursement in the amount of $29.25 is recommended.

Therefore, it is the conclusion of the Medical Review Division that additional reimbursement in the amount of $29.25 is due the requestor.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.201
28 Texas Administrative Code Sec. §134.202
28 Texas Administrative Code Sec. §134.202(e)(6)(C) (i)(1) and (D)(II)(a)

PART VII: DIVISION DECISION AND ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the Division has determined that the requestor **is** entitled to additional reimbursement in the amount of **$29.25**. 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 30-days of receipt of this Order.

Ordered by:

Authorized Signature	Typed Name	01/20/06 Date of Order

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005]. An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. The Division is not considered a party to the appeal.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.