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 Southwest Center Medical 7125 Marvin D. Love #107 Dallas, TX 75237	MDR Tracking No.: M4-05-9578 (previously M4-05-1209-01) TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: TIG Insurance Co. c/o Hammerman & Gainer	Date of Injury: Employer's Name: Mustang Masonry Inc. Insurance Carrier's No.: 00B01136595

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			
12/16/03	12/16/03	99456-WP	$150.00	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

The carrier did not pay our procedure 99456-WP according to 2003 TWCC MFG.

PART IV: RESPONDENT'S POSITION SUMMARY

Bill was reduced pursuant to Rule 134.202(e)(6)(C)(iii). Referral doctor, Dr. Berg, isnot the treating doctor and has not treated the claimant for his compensable injury.

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

Review of this dispute reveals the disputed issue is additional reimbursement for a musculoskeletal body area examination performed during and MMI/IR exam.

Pursuant to Rule 133.307(g)(3) the Commission requested additional information from the Requestor in the form of a letter mailed on October 21, 2004. The Requestor did not submit pertinent medical records to support additional reimbursement for the musculoskeletal body area billed. Therefore, additional reimbursement is not 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 not entitled to (additional) reimbursement.

Ordered by:

	Marguerite Foster	July 8, 2005
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: _____