



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: Killeen Rehab Group 5445 La Sierra Drive, Suite 204 Dallas, TX 75231	MDR Tracking No.: M4-05-A571-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Hartford Underwriters Insurance Rep Box # 27	Date of Injury:
	Employer's Name: Materials Transportation Co.
	Insurance Carrier's No.: YHZA 76638

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor states the carrier has denied payment for the patients claim and the patients recovery would have been negatively impacted without this treatment.

Principle Documentation:

1. Requestor's position statement
2. TWCC-60
3. EOB's
4. HCFA's

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent did not submit a position summary.

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)
03/03/05	F	97750	1	\$320.67
TOTAL DUE				\$320.67

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. CPT Code 03/03/05 for date of service 03/03/05 denied with "F". Per Rule 134.202(b) and CMS (Center For Medicare Services) reimbursement in the amount of \$320.67 (\$28.50 x 125% = \$35.63 x 9 units + \$320.67) is recommended.

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

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 \$320.67.**

Ordered by:

03/31/06

Authorized Signature

Typed Name

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.