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: Southeast Health Services PO Box 170336 Dallas TX 75217	MDR Tracking No.: M4-04-2543-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Zurich American Ins. Co. Rep Box #: 19	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documentation:

1. TWCC-60
2. HCFA's
3. SOAP notes / Examination Form

Position Summary: "Claims sent via mail twice with no response from insurance company in the form of payment or denial…Prior authorization obtained…See attached."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documentation: 1. Respondent's response to MDR.

Position Summary: "…The carrier asserts that it has paid according to applicable fee guidelines and /or reduced to fair and reasonable. Further, the carrier asserts that the charges are inconsistent with applicable fee guidelines. All reductions of the disputed charges were made appropriately…"

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	Denial Code	CPT Code(s) or Description	Part V Reference	Additional Amount Due
11/11/02 – 12/6/02	Unknown	99213, office visit 97265, joint mobilization 97545-WC, work conditioning 97546-WC, work conditioning	1.	$00.00
TOTAL DUE				$00.00

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

1. Section 413.011 (a-d) titled (Guidelines and Medical Policies), and Commission Rule 134.201 titled (Medical Fee Guideline (MFG) For Medical Treatments and Services Provided Under the Texas Worker's Compensation Act) effective April 1, 1996, set out reimbursement guidelines.

MDR = Medical Dispute Resolution DOS = Date(s) of Service

This dispute is related to lack of reimbursement for treatment/services provided on 11/11/02 thru 12/6/02.

- MDR received this dispute from the Requestor on 10/20/03.
- The date of the HCFA-1500 indicates the bills were submitted to the Respondent on 10/15/03 according to rule 133.304.
- The Respondent did not send in any EOB's for the dates of service in dispute with their response.
- The Requestor did not submit information that would substantiate that they presented DOS 11/11/02, 11/12/02, 11/13/02, 11/15/02 and 12/6/02 to the Respondent in a timely manner for requesting reimbursement according to rule 133.305(a) and 133.307(e). Therefore MDR does not have jurisdiction to determine any recommended reimbursement.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec.§ 413.011(a-d)
28 Texas Administrative Code Sec. §134.1
28 Texas Administrative Code Sec. §133.304
28 Texas Administrative Code Sec. §133.305
28 Texas Administrative Code Sec. §133.307

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 not** entitled to additional reimbursement**.**

Ordered by:

Authorized Signature	Typed Name	3 / 16 / 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.