MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: ( ) HCP (x) IE ( ) IC	**Response Timely Filed?** () Yes ( ) No
Requestor's Name and Address	MDR Tracking No.: M5-05-1518-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address BOX #: 47 American States Ins. Co. c/o SAFECO Po Box 461 St Louis MO 63166	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

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			
12/9/04	12/9/04	ESI at L4-5	$1,169.85	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

1/20/05: Injured worker is requesting reimbursement for out-of-pocket expenses for ESI's preformed/completed on date of service 12/9/04. Injured worker paid Dr. Edwards, and Corpus Christi Outpatient Surgery, and the Anesthesiologist on 12/14/04.

PART IV: RESPONDENT'S POSITION SUMMARY

3/18/05: Safeco representative, Terry Wright responded to the medical dispute submitted by the injured worker by acknowledging that "the ESI required preauthorization which was not obtained."

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

- The doctor's office requested preauthorization on 12/6/04.
- The carrier submitted a denial of the certification of the ESI request on 12/7/04.
- On 12/9/04, the treating doctor performed the ESI to the lumbar area at an outpatient facility.
- On 12/10/04, the treating doctor submitted an appeal letter in regards to the 'preauthorization request denial' on the ESI's.
- According to Rule 134.600 (h)(2), preauthorization for outpatient or ambulatory surgical services must be obtained prior to any treatment rendered pertaining to a worker's compensation injury.
- The preauthorization process includes a "Request for reconsideration" upon receipt of a denial.
- Treatment was rendered prior to a completion of the preauthorization process, therefore reimbursement can not be recommended.

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 not entitled to (additional) reimbursement.

		6/3/05
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: _____