



**MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION**  
**Retrospective Medical Necessity and Fee Dispute**

**PART I: GENERAL INFORMATION**

|   |                                 |
|---|---------------------------------|
| <b>Type of Requestor:</b> (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier                     |                                 |
| Requestor's Name and Address:<br><br>Summit Rehabilitation Centers<br>2500 W. Freeway #200<br>Ft. Worth, TX 76102 | MDR Tracking No.: M5-06-0985-01 |
|   | Claim No.:                      |
|   | Injured Employee's Name:        |
| Respondent's Name and Address:<br><br>Tokio Marine and Fire Ins Co Ltd., Box 47                                   | Date of Injury:                 |
|   | Employer's Name:                |
|   | Insurance Carrier's No.:        |

**PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY**

Documents include the DWC 60 package. Position paper states, "Provider sent a request for reconsideration. Proof that carrier received request is also included. Carrier chose not to respond within the 28 day time frame rule."

**PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY**

Documents include the DWC 60 response.

**PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services**

| Date(s) of Service | CPT Code(s) or Description                     | Medically Necessary? | Additional Amount Due (if any) |
|--------------------|--|----------------------|--------------------------------|
|                    | Requestor withdrew medical necessity services. |                      |                                |
|                    |  |                      |                                |
|                    |  |                      |                                |
|                    |  |                      |                                |

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

In a letter dated 3-3-06 the Requestor withdrew the medical necessity issues. Therefore, the file contains unresolved medical fee issues only. The Division shall proceed to resolve the medical fee dispute in accordance with Rule 133.307.

Regarding CPT code 99080-73 on 7-1-05: The carrier denied this service with a "W9" for unnecessary medical treatment based on a peer review; however, the DWC-73 is a required report per Rule 129.5 and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter; Recommend reimbursement of \$15.00.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION**

28 Texas Administrative Code Sec. 129.5 and 133.307.

**PART VII: DIVISION DECISION**

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 \$15.00. 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.

Findings and Decision and Order by:

Donna Auby

3-6-06

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.**