



## MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

### PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> <input checked="" type="checkbox"/> Health Care Provider <input type="checkbox"/> Injured Employee <input type="checkbox"/> Insurance Carrier	
Requestor's Name and Address:  Jerry M. McShane, D.O. 321 W. San Augustine Deer Park, TX 77536	MDR Tracking No.: M5-06-1494-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:  Service Lloyd's Insurance Company, Box 42	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, "How is it fair that our doctor not be paid for his services performed? It is not our designated doctor's fault for showing for a scheduled designated doctor appointment scheduled by the commission."

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

Documents include DWC 60 response.

### 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)
2-23-06	50-not deemed medically necessary	CPT code 99456-WP	1	\$500.00
Total				\$500.00

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

On 5-9-06 the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

1. Per Rules 134.202 (e)(6)(C)(iii) and 134.202 (e)(6)(D)(iii) and the AMA Guides 4<sup>th</sup> edition the requestor provided documentation to support a full physical exam.

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

28 Texas Administrative Code Sec. § 413.011(a-d)  
 28 Texas Administrative Code Sec. § 134.100  
 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 \$500.00.**

Ordered by:

Donna Auby, Medical Dispute  
Officer

6-2-06

\_\_\_\_\_  
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.**