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: **Town East Rehabilitation** **1125 Town East Mall** **Mesquite TX 75150**	MDR Tracking No.: M5-06-1528-01 Claim No.: Injured Worker's Name:
Respondent's Name and Address: **Sentry Insurance c/o FOL Rep Box #19**	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documentation: DWC 60 package. Requestor's position statement – "We request that you review and determine medical necessity for the treatment and services provide to [IW]. Denial of these claims has been denied as not medically necessary based on peer review. The peer review agrees with the diagnosis and treatment plan provided. Contrary to the peer review, carrier denied the above claim.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documentation: Carrier did not respond to DWC-60

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	Denial Code	CPT Code(s) or Description	Part V Reference	Amount Due (if any)
7-20-05 to 9-30-05	50	On 5-14-06, the Requestor faxed a letter withdrawing the medical necessity issues.	NA	NA
10-11-05	V	99455-V5-WP, 99080-69	1,2	$455.18
TOTAL DUE				$455.18

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

1. Code 99455-V5-WP billed on 10-11-05 was denied with reason code '50'. This service is required by DWC and not subject to an IRO review; therefore the carrier denied inappropriately. The billing of code 99455-V5-WP is in compliance with Rule 134.202(e)(6)(C)(i)(II) and (D)(iii)(II)(b); therefore, recommend reimbursement of $155.18 + $300.00 = $455.18.

2. Code 99080-69 is included with the reimbursement of 99455-WP per rule 134.202 (e)(6)(A)(iv); therefore, no additional reimbursement recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec.§ 413.011(a-d)
28 Texas Administrative Code Sec. §134.1, 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 reimbursement **in the amount of $455.18.**

Ordered by:

		5-22-06
	Medical Dispute Resolution Officer	
Authorized Signature	Typed Name	Date

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.