



**MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION**  
**Retrospective Medical Necessity**

**PART I: GENERAL INFORMATION**

<b>Type of Requestor:</b> ( X ) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor=s Name and Address:  El Campo Memorial Hospital 303 Sandy Corner Road El Campo, TX 77437	MDR Tracking No.: M5-06-1727-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:  American Home Assurance Company, Box 19	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

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

- Principle Documentation:
1. DWC-60/Table of Disputed Services
  2. CMS-1500's
  3. EOBs

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

- Position Summary: "...After review of this request, no further payment was recommended towards the amount in dispute...."
- Principle Documentation:
1. DWC-60/Table of Disputed Services/Position Summary
  4. CMS-1500's
  5. EOBs

**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)
12-3-05	72148	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
	Total Due		\$0.00

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

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code and Division Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), Medical Dispute Resolution assigned an Independent Review Organization (IRO) to conduct a review of the medical necessity issues between the Requestor and Respondent.

The Division has reviewed the enclosed IRO decision and determined that the Requestor did not prevail on the disputed medical necessity issues.

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

28 Texas Administrative Code Sec. 133.308 and 134.1  
Texas Labor Code 413.031

**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 not entitled to reimbursement for the services involved in this dispute.

Findings and Decision by:

Medical Dispute Officer

8-10-06

Authorized Signature

Typed Name

Date of Findings and Decision

**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.**