



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:	MDR Tracking No.:	M5-07-0026-01
	Claim No.:	
	Injured Employee's Name:	
Respondent's Name: 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

No Position Summary was received by the Requestor.

Principle Documentation:

1. DWC 60 package
2. Document from pharmacy showing out-of-pocket expenses

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary states in part, "Enclosed please find documents responsive to this issue for your review. I am filing the DWC-60 form on behalf of the above-referenced insurance carrier in response to the Requestor's dispute for fee reimbursement for the dates of service from August 20, 2004 through January 3, 2005."

Principle Documentation:

1. DWC 60 package
2. Copy of print screen showing check number of check reimbursing Requestor for all timely expenses.

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)
2-6-05 – 12-24-05	No EOB's	Prescription medications	1	\$00.00
	Total Due			\$00.00

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

Section 413.011(a-d) titled (Guidelines and Medical Policies), and Division Rule 134.202 titled (Medical Fee Guideline) effective August 1, 2003, set out reimbursement guidelines.

Dates of service 8-20-04 – 1-3-05 per Rule 133.308(e)(1) were not timely filed and are ineligible for review.

1. The Respondent sent a print screen indicating that it reimbursed the Injured Worker for all expenses in check number 2313881 on 10-25-06 in the amount of \$112.49. The Medical Dispute Resolution Officer talked to this injured worker on 11-06-06. He did confirm that he had received the check from the Respondent and that these services were no longer in dispute.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 413.011(a-d), 413.031
28 Texas Administrative Code Sec. 134.1

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 no additional reimbursement.

Finding and Decision by:

		11-06-06
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.