



## MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

### Retrospective Medical Necessity

#### PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address:

Injury One Treatment Center  
5445 La Sierra Dr., Suite 204  
Dallas, Texas 75231

MDR Tracking No.:

Claim No.:

Injured Employee's Name:

Respondent's Name and Address:

SERVICE LLOYDS INSURANCE CO, Box 42

Date of Injury:

Employer's Name:

Insurance Carrier's No.:

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

Position Summary: "It is our position that Service Lloyds Insurance has established an unfair and unreasonable time frame in paying for the services that were authorized and rendered to Mr. Beardsley."

Principle Documentation:

1. DWC-60/Table of Disputed Services/Position Summary
2. CMS-1500's
3. EOB's

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

Position Summary: "Harris and Harris represents Service Lloyds Insurance in this matter... Thank you for your consideration."

Principle Documentation:

1. DWC-60/Table of Disputed Services/Position Summary

#### 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)
12-12-05 - 2-2-06	97545-WH-CA, 97546-WH-CA, 97750-FC	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
	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. No reimbursement recommended.

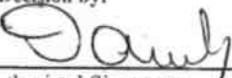
**PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION**

Texas Labor Code 413.011(a-d) and 413.031  
28 Texas Administrative Code Sec, 133.308 and 134.1

**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 of the IRO fee and is not entitled to reimbursement for the services involved in this dispute.

Findings and Decision by:

  
Authorized Signature

Donna Auby, Medical Dispute Officer  
Typed Name

01-08-07  
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.