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: Debbie Crawford, D.O. 3804 Highway 377 South Brownwood, Texas 76801	MDR Tracking No.: M4-05-0373-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Ace American Insurance Company C/o Ace USA/ESIS Rep Box # 15	Date of Injury: Employer's Name: American Habilitation Services Insurance Carrier's No.: C290C6128199

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

"I have received two denials from the insurance carrier on Charles Nicks denying a CBC done on 01/06/2004. The CBC was done for medication maintenance due to his multiple medications. The medication being addressed is Remeron. I am referring to *PDR Monthly Prescribing Guide*, April 2004, and will have copies of this submitted with this dictation. To Medical dispute, under the warnings and precautions, risk of agranulocytosis, discontinue if develop sore throat, fever, or stomatitus, along with low WBC. The next medication is Mobic and under warnings and precautions, risk of GI ulceration, risk of GI bleed, and also monitoring Hgb and Hct if signs of anemia occur. The reasons CBC were needed was to ensure that Mr. Nicks was given his medications in a safe manner without running a laboratory on Mr. Nicks, I cannot properly evaluate his capability to take these medications, these medications were prescribed for this low back pain which are a compensability to his injury."

Principle Documentation:
1. Requestor's position summary
2. TWCC 60/Table of Disputed Services
3. CMS 1500
4. Explanation of Benefits
5. Report dated 01/06/04

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Respondent did not submit a response to this dispute request.

Principle Documentation:
1. N/A

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)
01/06/04	R	85025 (Blood Count/Complete Automated)	1	$13.58
TOTAL DUE				$13.58

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

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

1. Code 85025 for date of service 01/06/04 was denied as "R—Services Do Not Appear Related to Work Injury/Diagnosis". The Respondent failed to file a TWCC-21 with the Commission disputing compensability or extent of injury in accordance with Section 408.027; therefore, the services will be reviewed in accordance with the Medicare Fee Schedule. Rule 134.202(c)(6) states, "for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assigned a relative value, which may be based on nationally recognized published relative studies, published commission medical dispute decisions, and values assigned for

services involving similar work and resource commitments." Carrier failed to assign a relative value and reimbursed the Requestor $00.00.

The Requestor billed the Respondent $25.00 for CPT code 85025. Per the Requestors Table of Disputed Services, the amount in dispute is $13.58. Therefore, reimbursement in the amount of $13.58 is recommended.

Therefore, it is the conclusion of the Medical Review Division that reimbursement in the amount of $13.58 is due the requestor.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.201
28 Texas Administrative Code Sec. §134.202
28 Texas Administrative Code Sec. §408.027

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 **$13.58**. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30-days of receipt of this Order.

Ordered by:

Authorized Signature	Typed Name	02/02/06 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.