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: Americare Pain Management 3301 B N. Main St. Ft. Worth, TX 76106	MDR Tracking No.: M4-05-0921-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: St. Paul Guardian Insurance Co. C/o Law Offices of Patrick Grove Rep Box #: 05	Date of Injury: Employer's Name: S. J. Louis Construction, Inc. Insurance Carrier's No.: WVK6300917 09W013

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Requestor's position summary states in part, "…There have been multiple correspondences regarding the unpaid services with the carrier. Copies of that correspondence, is included as a part of this submission. Our position for reimbursement is clearly outlined in the already mentioned letters. Additionally, the denied services required pre-authorization which was completed prior to services being provided…"

Principle Documentation:

1. Requestor's position summary
2. EOBs
3. Clinical notes

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Respondent did not submit a position summary or response to the request for medical dispute resolution.

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)
02/04/04	A	90899-QU – Unlisted psychiatric procedure or service	1	$00.00
02/05/04 & 03/18/04	N	97750 – Physical Performance Test	1	$00.00
02/06/04	F	99245-QU – Office Consultation	1	$00.00
05/20/04 – 05/24/04	No EOB	97799-CP – Chronic Pain Management	1	$00.00
TOTAL DUE				$00.00

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

1. Review of the documentation included in the request for dispute resolution reveals that per §133.307(e)(2)(A) the requestor did not submit a copy of all medical bills as originally submitted to the carrier for reconsideration in accordance with §133.304; therefore, services rendered as billed could not be determined and reimbursement is not recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec.§ 413.011(a-d)
28 Texas Administrative Code Sec. §134.304
28 Texas Administrative Code Sec. §133.307

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 not** entitled to reimbursement.

Decision by:

	Marguerite Foster	December 19, 2005
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.