MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: ( ) HCP ( ) IE (X) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Texas Mutual Insurance Company c/o Reeves & Brightwell 8911 N. Capital of Texas Hwy , Westech 360, Suite 3210 Austin, TX 78759-7249	MDR Tracking No.: M4-05-4247-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Universal Medical Evaluators, Inc. c/o Minton, Burton, Foster, & Collins, P.C. 1100 Guadalupe Austin, TX 78701	Date of Injury: Employer's Name: Word of God Fellowship, Inc. Insurance Carrier's No.: 99D0000353016

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		**CPT Code(s) or Description**	**Amount in Dispute**	**Amount Due**
From	**To**			
2/13/04	**2/13/04**	**99456-WP**	**$650.00**	**$0.00**

PART III: REQUESTOR'S POSITION SUMMARY

The carrier has filed a request for a refund based on noncompliance by the provider with multiple TWCC requirements.

PART IV: RESPONDENT'S POSITION SUMMARY

The Claimant-doctor did not charge fees in excess of those allowed by medical policies or fee guidelines, and fee refunds under Texas Labor Code § 413.016 are therefore not required. The fee charged by claimant-doctor was within range permitted by TWCC guidelines, and was the claimant-doctor's usual fee for services rendered.

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

Per Rule 133.304 (p), "an insurance carrier may request medical dispute resolution in accordance with §133.305 if the insurance carrier did not earlier make full payment on the medical bill in accordance with §413.031 of the Texas Labor Code…"

The insurance carrier filed for medical dispute resolution on 2/11/05 (refund request). Review of the file reveals that on 2/25/04, the provider billed the carrier $650.00 for a DDE rendered on 2/13/04. On 3/28/04, the insurance carrier audited the bill and made full payment in the amount of $650.00 to the provider for the disputed service. The insurance carrier did not submit evidence of an overpayment, payment denial, or reduction of payment for the disputed service. Therefore, the Medical Review Division declines to issue an Order in this dispute. Since the insurance carrier made full payment on this medical bill, the provisions of §133.304 (p) prevent consideration of the other factual disputes presented in this particular case.

PART VI: DETAIL FINDINGS (If needed)

N/A

PART VII: COMMISSION DECISION

Based upon the review of the disputed healthcare services as outlined above, the Medical Review Division has determined that the requestor is not entitled to a refund.

Authorized Signature	Pat DeVries Typed Name	5/05/05 Date

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, 7551 Metro Center Dr., Suite 100, 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____