MEDICAL DISPUTE RESOLUTION DISMISSAL

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address HCA Healthcare 6000 NW Parkway Suite 124 San Antonio, TX 78224	MDR Tracking No.: M4-05-6871-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Texas Mutual Ins. Co./Rep. Box: 54 P.O. Box 12029 Austin, TX 78711	Date of Injury: Employer's Name: Kingston Manufacturing Co. Insurance Carrier's No.: 93015189

PART II: DISMISSAL REASON

☐ The requestor informed the commission, or the commission has otherwise determined, that the dispute no longer exists.

☐ The individual or entity requesting dispute resolution is not a proper party to the dispute.

X The commission has determined that the medical bills in dispute have not been properly submitted to the carrier for reconsideration pursuant to §133.304.

☐ The fee disputes for the date(s) of health care in dispute have previously been adjudicated by the commission.

☐ The request for dispute resolution is untimely.

☐ The requestor failed to remit the fee for an IRO review.

☐ The request for medical dispute resolution does not contain all the components required. The requestor may amend and resubmit the request to include the required elements as long as it is filed within the appropriate timeframe.

X The commission has determined that good cause exists to dismiss this request based on: Commission Rule 133.304 (k) provides for the reconsideration process when a sender of a bill is dissatisfies with the insurance carrier's final action on a medical bill. The request for reconsideration shall be submitted by facsimile or mutually agreed electronic transmission or send the request by mail or personal delivery.

Commission Rule 133.307(e)((2)(A)(B), requires the Requestor to provide convincing evidence of carrier receipt of the provider request for an explanation of benefits (EOB).

In review of the Requestor's submitted information, convincing evidence of carrier receipt of the request for reconsideration was not provided. Therefore, this dispute is dismissed.

PART III: COMMISSION DISMISSAL

This request for medical dispute resolution has been dismissed based on the reason(s) listed above. If you disagree with this action, you may request reconsideration by submitting a request in writing within 20 days of your receipt of the dismissal. Your request should clearly explain the reason for your disagreement and include any documents that support your position. Requests for reconsideration should be sent to: Director, Medical Review Division (MS-40), 7551 Metro Center Drive, Suite # 100, Austin, Texas 78744.

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

Ordered by:

	Roy Lewis	6-7-05
Authorized Signature	Typed Name	Date of Dismissal