## MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Type of Requestor: () HCP () HC (X) IC Response Timely Filed? (x) Yes () No   Requestor: Name and Address MDR. Tracking No.: M4-05-8508-01   Texas MUtual Insurance Company For address MURE Tracking No.: M4-05-8508-01   Statistic Company For address Mure Tracking No.: Mure Tracking No.:   Statistic Company For address Mure Tracking No.: Mure Tracking No.:   Statistic Company For address Mure Tracking No.: Mure Tracking No.:   Statistic Company For address For address Mure Tracking No.:   Statis Company For C	PART I: GENERA	L INFORMATION						
Texas Mutual Insurance Company M44-03-8308-01   VICE No:: Injurd Employer's Name:   8911 N. Capital of Texas Hwy, Westech 360, Suite Injurd Employer's Name:   3210 Austin, TX 78759-7249   Respondent's Name and Address Injurd Employer's Name:   Universal Medical Evaluators, Inc. c/o Minton, Burton, Foster, & Collins, P.C.   100 Guadalupe Image of Service   Austin, TX 78701 Employer's Name:   PART III: SUMMARY OF DISPUTE AND FINDINGS (Decils on Page 2, if needed) Amount in Dispute   From To   610:04 6/10:04   990000341074 Amount Due   FART III: REQUESTOR'S FOSITION SUMMARY Inc.   The carrier has filed a request for a refund based on noncompliance by the provider with multiple TWCC requirements. FART V: RESPONDENT'S FOSITION SUMMARY   PART V: RESPONDENT'S POSITION SUMMARY UMF states in part, "By these requests it seeks reimbursement for fees paid to those doctors despite the fact that it received precisely the health care services it paid for at rates within TWCC-approved guidelines"   PART V: MEDICAL DISPUTE RESOLUTION REVEW 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 filed for medical dispute resolution on June 2, 2005 (	Type of Requestor:	() HCP () IE (X	C) IC					
c/o Recves & Brightwell Invert Not Service Injured Employee's Name:   210 Insurance Carrier's Not Service Insurance Carrier's Not Service   CPT Code(s) or Description Amount in Dispute   Austin, TX 78701 Employee's Name:   PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2; if needed) 99D0000341074   Dates of Service CPT Code(s) or Description Amount in Dispute   6/10/04 6/10/04 99456 \$350.00 \$0.00   PART II: REQUESTOR'S POSITION SUMMARY Employee's nume: From CPT Code(s) or Description Amount in Dispute   PART III: REQUESTOR'S POSITION SUMMARY Employee's nume: From CPT Code(s) or Description Amount in Dispute   PART III: REQUESTOR'S POSITION SUMMARY Employee's nume: From CPT Code(s) or Description Amount in Dispute   PART III: REQUESTOR'S POSITION SUMMARY Employee's nume: From CPT Code(s) or Description Amount in Dispute   PART III: REQUESTOR'S POSITION SUMMARY Employee's nume: From CPT Code(s) or Description   PART V: RESPONDENT'S POSITION SUMMARY Employee's nume: From From From   PART V: REQUESTOR'S POSITION SUMMARY F	-			1014-05-8508-01				
8911 N. Capital of Texas Hwy, Westech 360, Suite 3210 Injurd Employee's Name:   3210 Austin, TX 78759-7249   Regondent's Name and Address Date of Injury:   Universal Medical Evaluators, Inc. c'o Minton, Burton, Foster, & Collins, P.C. Insurance Carrier's Non:   100 Guadalupe Insurance Carrier's Non: Part II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)   PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed) Amount in Dispute Amount Due   6/10/04 6/10/04 99456 \$350.00 \$0.00   PART II: REQUESTOR'S POSITION SUMMARY The carrier has filed a request for a refund based on noncompliance by the provider with multiple TWCC requirements.   PART II: RESPONDENT'S POSITION SUMMARY UME states in part, "By these requests it seeks reimbursement for fees paid to those doctors despite the fact that it received precisely the health care services it paid for at rates within TWCC-approved guidelines"   PART IV: RESPONDENT'S POSITION NUMARY 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 §133.305 if the insurance carrier s350.00 for a Designated Doctor Exam rendered on 6/10/04. The insurance carrier make full payment on the medical bill in accordance with §133.305 if the insurance carrier s350.00 to prove Designated Doctor Exam rendered on 6/10/04. The insurance carrier make full payment on this medic		1 0		TWCC No.:				
3210 Austin, TX 78759-7249   Respondent's Name and Address Date of Injury:   Universal Medical Evaluators, Inc. Employer's Name:   r/o Minton, Burton, Foster, & Collins, P.C. Insurance Carrier's No:   1100 Guadalupe Insurance Carrier's No:   Austin, TX 78701 Employer's Name:   From To   0/0/004 6/10/04   6/10/04 6/10/04   99456 \$350.00   S350.00 \$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   UME states in part, "By these requests it seeks reimbursement for fees paid to those doctors despite the fact that it received precisely the health care services it paid for at rates within TWCC-approved guidelines"   PART V: REDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION   Per Rule 133.304 (p), "an insurance carrier may request medical dispute resolution on in accordance with §133.305 if the insurance carrier did not earlier make full payment on the medical bill in accordance with §133.305 if the insurance carrier did not earlier make full payment on the medical bill in accordance of an overpayment, payment denial, or reduction of payment of \$350.00 to the provider for the disputed service. Therefore, the Medical Review Oith file revea		U	stech 360, Suite	Injured Employee's Name:				
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## PART VI: DETAIL FINDINGS (If needed)

N/A

FANI	VIII:	COMMISSION DECISION

Authorized Signature

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.

Pat DeVries

Typed Name

June 22, 2005

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.

Date: