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.: M4-05-8720-01 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: Colours of the Rainbow Granite Insurance Carrier's No.: 99C0000302858

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**			
10/7/04	**10/7/04**	**99456**	**$700.00**	**$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 that "under Texas Labor Code §413.016 the Medical Review Division may only order refunds of amounts paid health care providers 'in excess of those allowed by the medical policies and fee guidelines.'

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

Neither the Requestor nor the Respondent in this dispute provided CMS 1500s in accordance with Rule 133.307(e)(2)(A). The reviewer is unable to substantiate the level of service billed or confirm the rate of reimbursement per Rule 134.202(e)(6) of the MFG. Therefore, MDR declines to issue an order for carrier refund.

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.

	Regina Cleave	June 22, 2005
Authorized Signature	Typed Name	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: _____