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: ( ) Health Care Provider (X) Injured Employee ( ) Insurance Carrier

Requestors Name and Address: DAWN M. MCDONALD 3300 Lansing Switch Rd Lot #126 Longview, TX 75602	MDR Tracking No.: M4-05-A722-01 Claim No.: Injured Employee's Name:
Respondent's Name: Universal Underwriters Insurance, Box 10	Date of Injury: Employer's Name: ABC Auto Parts Ltd. Insurance Carrier's No.: 2230093296

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary states in part, "I was under the impression that I had lifetime medical benefits from the day I got hurt. I am unable to pay for tests, office visits, procedures, and prescriptions. I feel it is the insurance carrier's responsibility, not mine!"

Principle Documentation:

1. DWC 60 package
2. CMS 1500's
3. EOBs

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

No Position Summary was received from the Respondent.

No documentation was received from the Respondent.

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)
1-29-05, 3-29-05, 5-27-05	No EOB	Hydrocodone/APAP	1, 2	$209.17
2-18-05	No EOB	Cyclobenzapr (Flexiril)	1, 2	8.64
6-30-05	No EOB	Tramadol	1, 2	56.99
7-17-05	No EOB	Mobic	1, 2	101.99
Grand Total				$376.79

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

Section 413.011(a-d) titled (Guidelines and Medical Policies), and Division Rule 134.202 titled Subchapter F, Pharmaceutical Benefits effective January 3, 2002, set out reimbursement guidelines.

1. On 8-4-06 the Medical Review Division submitted a Notice to the Respondent to submit documentation necessary to support its denial of reimbursement to the Injured Worker. No response was received from the Respondent.

2. The Respondent did not provide a reconsideration response per Rule 133.304. Recommend reimbursement per Rule 134.503.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 413.011(a-d), 413.031
28 Texas Administrative Code Sec. §133.307
28 Texas Administrative Code Sec. 134.1, 134.502, 134.503, 134.504

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 entitled to additional reimbursement in the amount of $376.79. The Division hereby **ORDERS** the insurance carrier to remit this amount to the Requestor within 30-days of receipt of this Order.

Ordered by:

	Donna Auby, Medical Dispute Officer	11-06-06
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.