MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes (x) No
Requestor's Name and Address Valley Center for Pain & Stress 1401 East Ridge Road, Ste. D McAllen, TX 78503-1525	MDR Tracking No.: M4-05-0137-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Pacific Employers Insurance Co. c/o ACE USA/ESIS Box 15	Date of Injury: Employer's Name: Affiliated Computer Services Insurance Carrier's No.: 023050000145660001

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			
12/11/04	12/11/04	96150	$540.00	$0.00
12/31/04	01/30/04	97799-CP	$6,000.00	$2,400.00

PART III: REQUESTOR'S POSITION SUMMARY

Position Summary states in part, "…At this time, I feel that we have made attempt to resolve this matter with the insurance carrier to avoid this action, but have not been successful. Valley Center for Pain & Stress Management's services were pre-authorized and determined medically necessary to the compensable injury…."

PART IV: RESPONDENT'S POSITION SUMMARY

The Respondent did not submit a response to the initial TWCC-60. On March 2, 2005 the Respondent was sent a memorandum requesting additional information. A response was not submitted to this request.

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

The submitted Table of Disputed Services lists dates of service to be 12/11/03, 12/31/03, 01/02/04, 01/06/04, 01/15/04, 01/29/04, 01/30/04. Per Rules 133.307(e)(2)(A) and 133.307(g)(3)(B) the Requestor did not submit HCFA-1500's and pertinent medical records for dates of service 12/11/03, 12/31/03, 01/29/04, and 01/30/04; therefore, MDR could not confirm services were rendered as billed. Reimbursement for these dates of service are not recommended.

- CPT Code 97799-CP (24 hours) for dates of service 01/02/04, 01/06/04 and 01/15/04 denied as "V". Per Rule 133.301(a) the insurance carrier may not retrospectively review the medical necessity of a medical bill for treatments/services that the health care provider has obtained preauthorization. The preauthorization number is: 03121719537812. Per Rule 133.307(g)(3)(B) the submitted medical records support services were rendered as billed. Per Rule 134.202(e)(5)(E)(i)(ii) the health care provider did not apply the-CA modifier determining this program was a CARF accredited program; therefore, reimbursement in the amount of $2,400.00 (24 hrs x $100/hr, 80% applied for non-CARF accredited program) is recommended.

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $2,400.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Or

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to (additional) reimbursement.

Ordered by:

	Marguerite Foster	04/11/05
Authorized Signature	Typed Name	Date of Order

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, P.O. Box 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 and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____