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

Requestors Name and Address: Forward Health Solutions P.O. Box 443 Burleson , TX 76097	MDR Tracking No.: M4-05-1780-01 Claim No.: Injured Employee's Name:
Respondent's Name: Continental Casualty Co. Rep Box # 47	Date of Injury: Employer's Name: Nabors Industries LTD Insurance Carrier's No.: 010929003002WC0

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary states in part, "…Preauthorized services were billed in accordance with TWCC guidelines and should be reimbursed at MAR.."

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

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary states in part, "…Respondent did not submit a position statement"

Principle Documentation: 1. Response to DWC 60
2. Copy of check # 0035328099 for $400.00

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)
10/27/03	03550,M	97799-CP x 7 hours	1	$500.00
11/03/03	03336,M	97799-CP x 5 hours	2	$300.00
TOTAL DUE				$800.00

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 (Medical Fee Guideline) effective August 1, 2003, sets out reimbursement guidelines.

1. CPT Code 97799-CP for date of service 10/27/03 denied with "03550- FHN contract status indicator –non contracted provider & "M- No MAR" According to Rule 134.202(e) (5) (E) (i) payment shall be $125.00 per hour for CARF accredited programs and 80% of MAR ($100.00 per hour) for non CARF accredited programs. The Respondent reimbursed the Requestor $200.00 for 7 hours of the Chronic Pain Management Program; therefore, per the 2002 Medical Fee Guideline an additional reimbursement of $500.00 (7 hours x $100.00 = $700.00 - $200.00 (insurance carrier payment) = $500.00) is recommended.

2. CPT Code 97799-CP for date of service 11/03/03 denied with "03336- Override UR rules use once per bill", & "M- No MAR". Per Rule 134.202 (e) (5) (E) (5) (i) payment shall be $125.00 per hour for CARF accredited programs and 80% of MAR ($100.00 per hour) for non CARF accredited programs. The Respondent reimbursed the Requestor $200.00 for 5 hours of the Chronic Pain Management Program; therefore, per the 2002 Medical fee Guideline additional reimbursement of $300.00 (5 hours x $100.00 = $500.00 - $200.00 (insurance carrier payment) = $300.00) is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 413.011(a-d)
28 Texas Administrative Code Sec. §134.1
28 Texas Administrative Code Sec. §134.202

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 **$800.00**. 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 30-days of receipt of this Order.

Ordered by:

		10/19/2006
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.