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

Requestor=s Name and Address: Positive Pain Management/Dr. Ron Zeigler, Ph.D. 2301 Forest Lane Ste 312 Garland, Texas 75042	MDR Tracking No.: M4-05-1979-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: State Office of Risk Management Box 45	Date of Injury: Employer's Name: State of Texas Insurance Carrier's No.: WC1842780

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: "I am disputing this claim for fee reimbursement for the Chronic Pain Management Program. Our office has attempted to resolve this issue with the carrier, S.O.R.M. on two (2) or more separate occasions., and sent the documentation for eight hours of the Program. It is my understanding that the TWCC/MDR basis[sic] it's F & D, solely on the original explanation of benefits (EOB) denial."

Principle Documentation:

1. DWC-60/Table of Disputed Service/Summary Position
2. CMS-1500's
3. EOB's

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: "…The Office notes that the requestor's documentation marked (Exhibit 1) submitted on 08/17/04 to support the number of hours billed for date of service 06/15/04 shows a discrepancy. It appears the number of hours listed on the original documentation received on 06/28/04 marked (Exhibit 2) shows 6 hours of chronic pain management for date of service 06/15/04 and the documentation submitted on 08/17/04 for the identical codes and charges shows 7 hours of chronic pain management without any justification for the additional hour added by the requestor."

Principle Documentation:

1. DWC-60/Table of Disputed Service/Position Summary
2. CMS-1500's
3. EOB's

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)
06/15/04	F1	CPT code 97799-CP-CA($125.00 x 0 units)	1 and 2	$0.00
06/17/04	F1	CPT code 97799-CP-CA ($125.00 x 1.5 units)	1 and 3	$187.50
07/30/04	F, 130	CPT code 97799-CP-CA ($125.00 x 1.5 units)	1 and 4	$187.50
Total				$375.00

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

1. The carrier denied these services as "F1-TWCC Code: F-Fee Guideline MAR reduction. Charge exceeds the schedule maximum allowance per the Medical Fee Guideline. F-130-Services unsubstantiated by documentation."

2. The Respondent denied services, "F1-TWCC Code: F-Fee Guideline MAR reduction. Charge exceeds the schedule maximum allowance per the Medical Fee Guideline". The Requestor's documentation does not support services for date of service 06/15/04 per Rule 134.202 (e)(5)(E). The Respondent reduced the amount reimbursed to the Requestor for the date of service 06/15/04 by $125.00. The Respondent indicated in their response that a discrepancy from the original documentation marked (Exhibit 1) submitted 06/28/04, indicates 2 hours of PPM time not 3 hours marked (Exhibit 2) submitted on 08/17/04. The Requestor submitted documentation indicating only 6 hours of Chronic Pain Program were administered not 7 as billed per the HCFA and no additional reimbursement is recommended.

3. The Respondent denied services, "F1-TWCC Code: F-Fee Guideline MAR reduction. Charge exceeds the schedule maximum allowance per the Medical Fee Guideline". The Requestor submitted documentation that supports services being rendered, indicating 8 hours of Chronic Pain Program were administered per Rule 134.202 (e)(5)(E). Respondent reduced the amount reimbursed to the Requestor for the date of service 06/17/04 by $187.50. Therefore, additional reimbursement in the amount of $187.50 is recommended.

4. The Respondent denied services, "F-130-Services unsubstantiated by documentation". The Requestor submitted documentation that supports services were rendered, indicating 8 hours of Chronic Pain Program were administered for the date of service 07/30/04 per Rule 134.202 (e)(5)(E). Respondent reduced the amount reimbursed to the Requestor by $187.50. Therefore, additional reimbursement in the amount of $187.50 is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Labor Code Sec.§ 413.031
28 Texas Administrative Code Sec. §134.100
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 $375.00.** The Division hereby ORDERS the Respondent to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30 days receipt of this Order.

Ordered by:

	Michael Bucklin	09/20/06
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.