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: Buena Vista Workskills 5445 La Sierra Drive, Suite 204 Dallas, Texas 75231	MDR Tracking No.: M4-05-4896-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Lumbermens Mutual Casualty Company C/o Harris & Harris Rep Box # 42	Date of Injury: Employer's Name: La Quinta Corp. Insurance Carrier's No.: 4650122333

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary states in part, "…The claim was paid below MAR. There were 6.5 units on the HCFA but it was audited and paid for 6 units. This was resubmitted and was received by the insurance on 01/22/2005. As of today we have not received the additional payment of $62.50…"

Principle Documentation:
1. DWC 60 package
2. CMS 1500s
3. EOBs
4. Medical Records

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary taken from the Table of Disputed Services states, "The provider has failed to meet it's burden of proof to establish that its charges and the amounts requested are 'fair and reasonable', and comply with Section 413.011(b) of the Texas Labor Code and Commission rules. The Carrier's reimb. complied with the requirements of section 413.011(h) of the Texas Labor Code and Commission rules, and is 'fair and reasonable'."

Principle Documentation:
1. Response to DWCC 60
2. DWC 60/Table of Disputed Services

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)
03/29/04	F	97799-CP-CA (Chronic Pain Management Program)	1-2	$00.00
TOTAL DUE				$00.00

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. This dispute relates to lack of full reimbursement for CPT code 97799-CP-CA (chronic pain management). The treatment/service was denied as "F—Fee Guideline MAR Reduction".

2. The Requestor did not submit convincing evidence of carrier receipt for "Request for Reconsideration EOBs" for date of service 03/29/04, in accordance with 133.307 (e)(2)(B). Therefore, this date of service is not eligible for review.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

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

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 not entitled to additional reimbursement.

Ordered by:

Authorized Signature	Typed Name	Date of Order
		09/29/06

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.