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: Jared Barker, L.O.T. 7125 Marvin D. Love, Suite 107 Dallas, Texas 75237	MDR Tracking No.: M4-05-5256-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: State Office of Risk Management Rep Box # 45	Date of Injury: Employer's Name: State of Texas Insurance Carrier's No.: 1742428

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary states in part, "…Our charges were originally sent to the carrier via certified mail. The carrier received on December 13,2004. The carrier did not respond to our request with in the required 45 days. We then submitted in our charges for a Request for Reconsideration as required by TWCC. The carrier at this time returned our charges stating that our request was not submitted with in the guidelines. TWCC has stated that when charge are originally submitted and not responded to then the provider must resubmit as a reconsideration. No further exception codes were documented to the provider for appeal…"

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

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary on Table of Disputed Services states, "The State Office of Risk Management will continue to maintain denial for supplemental payment regarding the disputed CPMP. It appears the provider/requester has not sought the request for reconsideration process thus deeming this Medical Fee Dispute ineligibility for pursuant to Rule §133.304(k)(1)(A,B)(2)(3), 133.307(e)(2)(A) and 133.307(m)(3)."

Principle Documentation:
1. Response to DWC 60

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)
11/08/04	F	97799-CP-CA (Chronic Pain Management Program) (8 hours)	1-6	$1,000.00
11/09/04	F	97799-CP-CA (Chronic Pain Management Program) (8 hours)	1-6	$1,000.00
11/10/04	F	97799-CP-CA (Chronic Pain Management Program) (8 hours)	1-6	$1,000.00
11/12/04	F	97799-CP-CA (Chronic Pain Management Program) (8 hours)	1-6	$1,000.00
11/15/04	F	97799-CP-CA (Chronic Pain Management Program) (8 hours)	1-6	$1,000.00
11/16/04	F	97799-CP-CA (Chronic Pain Management Program) (7 hours)	1-6	$875.00
11/18/04	F	97799-CP-CA (Chronic Pain Management Program) (7 hours)	1-6	$875.00

11/19/04	F	97799-CP-CA (Chronic Pain Management Program) (7 hours)	1-6	$875.00
TOTAL DUE				$7,625.00

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 CPT code 97799-CP-CA (chronic pain management) for dates of service 11/08/04, 11/09/04, 11/10/04, 11/12/04, 11/15/04, 11/16/04, 11/18/04 and 11/19/04.

2. The Requestor did not provide EOB's for dates of service 11/09/04 through 11/19/04. The Respondent provided a copy of the initial EOB indicating services were reimbursed.

3. The Requestor did submit convincing evidence of carrier receipt for "Request for Reconsideration EOB's" in accordance with 133.307(e)(2)(B). The Respondent did not provide a reconsideration response per Rule 133.304.

4. On 10/20/06, the Division contacted the Requestor to ascertain if the Respondent had made reimbursement according to EOBs submitted in their MDR response. Per Requestors' representative, Anna Morales, the Respondent has not reimbursed any monies regarding the disputed dates of service.

5. Per §134.202(e)(5)(E)(i-ii) reimbursement for the Chronic Pain Management Program (CPM) shall be $125.00 per hour for a CARF accredited program. A CARF accredited program for CPM is indicated by using the modifier – CA. The Requestor did provide the CARF accredited modifier; therefore, the monetary value of the program will be 80% of the CARF accredited value.

6. Per §134.202(b), reimbursement in the amount of $7,625.00 ($125.00 X 61 hours) 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(b) & (e)(5)(E)
28 Texas Administrative Code Sec. §133.307(e)(2)(B)

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 reimbursement in the amount of $7,625.00 plus all accrued interest due at the time of payment to the Requestor within 30-days of receipt of this Order..

Ordered by:

	Margaret Ojeca	10/20/06
Authorized Signature	Typed Name	Date of Order
	Debra Hausenfluck	10/20/06
Signature	Typed Name	Date

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.