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: Integra Specialty Group, P.A. 517 North Carrier Parkway, Suite G Grand Prairie, Texas 75050	MDR Tracking No.: M4-05-6739-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Irving Independent School District C/o Harris & Harris Rep Box # 42	Date of Injury: Employer's Name: Irving Independent School District Insurance Carrier's No.: 0S101350

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Requestor's Position Summary as stated on the Table of Disputed Services states, "Preauthorization obtained/appropriately documented."

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

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Respondent's Position Summary states in part, "…please note the Requestor has failed to file for medical dispute resolution in a timely fashion for a number of the dates-of-service at issue in this dispute…This eliminates dates-of-service April 12 through April 16,2004, from this dispute…Regarding the remaining services: it appears the Requestor initially sent the HCFA-1500s to the incorrect Third Party Administrator; Ward North America. The correct TPA is Tristar Risk Management. Unfortunately, Ward did not forward these bills to Tristar. When Tristar did receive the bills, they were bereft of supportive documention in the form of medical notes, leading to the denial of these services per code 'N' – not documented. Respondent Tristar is in receipt of the Requestor's additional documentation, and is in the process of re-evaluation the bills made the basis of this dispute. Should Respondent's position change, it will notify all parties immediately…".

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)
04/12/04-04/16/04	N, 241	97799-CP (Chronic Pain Management Program)	Untimely	$00.00
05/04/04	No EOBs	97799-CP (Chronic Pain Management Program) (8 hours)	1-2	$800.00
05/05/04	N, 241	97799-CP (Chronic Pain Management Program) (8 hours)	1-2	$800.00
05/06/04	N, 241	97799-CP (Chronic Pain Management Program) (8 hours)	1-2	$800.00
05/10/04	N, 241	97799-CP (Chronic Pain Management Program) (8 hours)	1-2	$800.00
05/11/04	N, 241	97799-CP (Chronic Pain Management Program) (8 hours)	1-2	$800.00
05/13/04	N, 241	97799-CP (Chronic Pain Management Program) (8 hours)	1-2	$800.00

05/18/04 09/24/04 10/01/04	N, 205	97012 (Mechanical Traction Therapy)	3	$19.21 $19.21 $19.21
05/18/04 09/24/04 10/01/04	F, 434	97140 (Manual Therapy)	4	$00.00 $00.00 $00.00
09/10/04	D, 277	99213 (Office Visit, Established Patient)	5	$68.24
TOTAL DUE				$4,925.87

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.

Per the Respondent's preauthorization approval letter, authorization # 126899, preauthorization was approved on 03/12/04 for Additional 20 Sessions Chronic Pain Management with a start date of 03/12/04 and an end date of 04/26/04.

Per the Respondent's preauthorization approval letter, authorization # 130165, preauthorization was approved on 03/24/05[04] for 10 Sessions Chronic Pain Management with a start date of 04/23/04 and an end date of 05/21/04.

The Requestor did submit convincing evidence of carrier receipt for "Request for Reconsideration EOBs" in accordance with 133.307(g)(3)(A). The Respondent did not provide a reconsideration response per Rule 133.304.

Medical Dispute resolution date stamped the initial Requestor's Request for Medical Dispute Resolution on 04/25/05. Per Rule 133.307(d)(1), dates of service 04/12/04, 04/13/04, 04/14/04, 04/15/04 and 04/16/04, are outside the one (1) year filing deadline and not eligible for review.

1. This dispute relates to CPT code 97799-CP (chronic pain management) for dates of service 05/04/04, 05/05/04, 05/06/06, 05/10/04, 05/11/04 and 05/13/04. Neither the Requestor nor the Respondent provided copies of initial or reconsideration EOBs, for date of service, 05/03/04, therefore, this service will be reviewed in accordance with the 2002 Medical Fee Guideline. Dates of service 05/05/04, 05/06/04, 05/06/04, 05/10/04, 05/11/04 and 05/13/04 were denied as "N, 241—Not Documented".

2. 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 not provide the CARF accredited modifier; therefore, reimbursement is 80% of the CARF accredited value. Therefore, reimbursement in the amount of $4,800.00 ($100.00 X 48 hours) is recommended.

3. This dispute relates to CPT code 97012 (mechanical traction therapy) for dates of service 05/18/04, 09/24/04 and 10/01/04 and was denied as, "N—Not documented" and "205—This charge was disallowed as additional information/definition is required to clarify service/supply rendered". Per §134.202(c)(i), documentation supports the level of service billed. Therefore reimbursement in the amount of $57.63 ($19.21 X 3) is recommended.

4. This dispute relates to CPT code 97140 (manual therapy) for dates of service 05/18/04, 09/24/04 and 10/01/04 and was denied as, "F, 434—Fee Guideline MAR Reduction". According to the Medical Fee Guideline, CPT Code 97140 is a component is CPT Code 97012 and is considered unbundled and therefore not separately payable. Therefore, reimbursement is not recommended.

5. This dispute relates to CPT code 99213 (office visit, established patient) for date of service 09/10/05 was denied as, "D—Duplicate charge", and " 277—These services/charges have been previously reviewed and payment recommended on another analysis, returned as a duplicate bill". The Respondent did not submit documentation to support it's charge of duplicate billing. Therefore, per §134.202(b) reimbursement in the amount of $68.24 ($54.59 x 125%) is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code, Section §413.011(a-d)
28 Texas Administrative Code Sec. §134.1
28 Texas Administrative Code Sec. §134.202(b)
28 Texas Administrative Code Sec. §133.307(d)(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 entitled to reimbursement in the amount of $4,925.87 plus all accrued interest due at the time of payment to the Requestor within 30-days of receipt of this Order.

Ordered by:

Authorized Signature	Typed Name	Date of Order
		11/02/06

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.