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: Edward F. Wolski, M.D./Wol + Med 2436 I-35 East, South, Suite 336 Denton, Texas 76205	MDR Tracking No.: M4-05-9212-01 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.: 133174

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Requestor's Position Summary states in part, "The carrier stated that the procedures were not documented. This facility documents according to TWCC medical fee guidelines and CARF. The carrier violated TWCC rule: Rule 134.304(c)…The carrier also mistakenly denied stating that the procedure performed were not part of the compensable injury. The carrier violated the above rule once again. The carrier did not respond to any of the request for reconsideration. The carrier violated TWCC rule: Rule 133.304…".

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, "…In a response dated 06/21/05 the Office stated denials would be maintained as previously issues. On 07/01/04 the Office received submitted billing from the requestor for date of service 06/23/04. An audit was performed and a denial was issues to the provider as not related to the compensable injury. A comment was listed on the Explanation of Benefits stating, 'Billed diagnosis needs to be more specific. Pain in limb does not appear to be related t the compensable injury.' The requestor billed using a diagnosis code of 729.5 'pain in limb' and states in a position statement submitted for medical dispute resolution that the visit was a follow-up post-operative office visit. However based on the medical claim file the claimant had surgery on October 19,2 000, the procedure performed was a shoulder arthroscopy. The requestor, again only referencing a diagnosis code of 729.5 'pain in limb', submitted a second bill for an office visit on 08/10/04. An audit was performed and a denial was issued to the requestor as not related to the compensable injury with a comment stating, 'diagnosis needs to be more specific to the injury.' As stated above the claimant had a shoulder arthroscopy done on 10/19/00, the claimant attended post-operative physical therapy until 12/22/00. Upon completion of the post-operative physical therapy the claimant ceased to received treatment for her compensable injury for three years. After three years of non-treatment the claimant began treating again on 089/19/03 consequently raising questions about the relatedness of the treatment to the original injury. The Office will maintain denial of dates of service 06/23/04 and 08/10/04 as not related to the compensable injury until further notified by the Commission. After further review of the documentation submitted for dates of service 08/11/04 and 08/13/04, the Office concluded the documentation does not support the reimbursement requested for the chronic pain management program. The documentation does not appear to be in compliance with Rule 133.1(3)(E)(i), which states the documentation shall substantiate the care given and the need for further treatment(s) and/or services, indicate progress, improvement and expected release dates. The documentation submitted for date of service 08/10/04 indicates the claimant had a break in therapy due to other medical problems. The documentation submitted for date of service 08/11/04 indicates the claimant had a pain level of zero with zero numbness in left arm and left hand. The documentation submitted for date of service 08/13/04 indicates the claimant had a pain level of 2 in her left should and had not complaints. The exercise chart submitted for both dates of service fails to indicate the amount of time spent performing each activity. There was not progress improvement indicated on either progress note. The requestor billed for 8 hours of chronic pain management however the documentation failed to indicate how much time was spent in each activity performed. As a result the documentation submitted did not clearly provide way to determine the actual number or hours to be reimbursed for each hour billed…".

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)
06/23/04	N, R/ N3, N	99213 (Office Visit, Established Patient)	1-2	$61.98
08/10/04	R3, 0	99213 (Office Visit, Established Patient)	1-2	$61.98
08/11/04	130, 0	97799-CP CA (Chronic Pain Management Program) (8 hours)	3-4	$1,000.00
08/13/04	105/130, 0	97799-CP CA (Chronic Pain Management Program) (8 hours)	3-4	$1,000.00
TOTAL DUE				$2,123.96

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.

The Requestor did submit convincing evidence of carrier receipt for "Request for Reconsideration EOBs" in accordance with 133.307(g)(3)(A).

The Requestor submitted an updated Table of Disputed Services on 10/10/06.

Although the EOB for dates of service 06/23/04 and 08/10/04 indicate that services were denied with an "R" (Extent of Injury) denial code, the Respondent failed to file a DWC PLN-11 with the Division disputing treatment in accordance with Section 408.027(d); therefore, the services will be reviewed in accordance with the 2002 Medical Fee Guideline.

1. This dispute relates to CPT 99213 (office visit, established patient) for dates of service 06/23/04 and 08/10/04. The Requestor provided an EOB for date of service 06/23/04 only denying this CPT code as "N3, N---Not Appropriately Documented, Documentation does not adequately identified/quantified services or supplies billed" and "R3—R—Extent of Injury". The Respondent provided copies of EOBs for dates of service 08/10/04, 08/11/04 and 08/13/04. Date of service 08/10/04 was denied as, "R—Extent of Injury" and "O-Denial after reconsideration. Dates of service 08/11/04 and 08/13/04 were denied as, "130—Services unsubstantiated by documentation", and "O-Denial after reconsideration".

2. Per Rule 134.202(b), documentation supports services rendered as billed. Therefore, reimbursement in the amount of $123.96 ($49.58 x 125% X 2) is recommended.

3. This dispute relates to CPT 97799-CPCA (chronic pain management) for dates of service 08/11/04 and 08/13/04, denied as "105—Additional information needed to review charges, F—Fee guideline MAR reduction [initial denial] and 130—Services unsubstantiated by documentation." 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 100% of the CARF accredited value.

4. Therefore, per Rule 134.202(c)(i), reimbursement in the amount of $2,000.00 ($125.00 X 16 hours = $2,000.00) is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code, Section §413.011(a-d)
Texas Labor Code, Section §408.027(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 reimbursement in the amount of $2,123.96 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.