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:	
Behavioral Healthcare Associates 4101 Greenbriar, Ste. 115 Houston, TX 77098	MDR Tracking No.: M4-05-9531-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address:	
Dolgencorp of Texas, Inc. C/o Flahive, Ogden & Latson Rep Box #: 19	Date of Injury: Employer's Name: Dolgencorp of Texas Insurance Carrier's No.: 20020010087011

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Requestor's position summary states in part, "…The carrier has reduced reimbursement for procedure 97799-CP. The rationale used by the carrier is 'Fee guideline reduction.' We disagree with the carrier's rationale as the guideline was not satisfied by the carrier…"

Principle Documentation:

1. Requestor's position summary
2. TWCC 60/Table of Disputed Services
3. CMS-1500
4. EOBs

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Respondent's position summary states in part, "…On October 26, 2004, the carrier prepared an EOB based upon the fee guidelines. The correct payment for 360 units is $600.00 rather than the $650.00 amount requested by the provider…"

Principle Documentation:

1. Respondent's position summary
2. TWCC 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)
06/11/04	F, 320	97799-CP – Chronic Pain Management Program	1	$50.00
TOTAL DUE				$50.00

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

Section 413.011(a-d) titled (Guidelines and Medical Policies), and Commission Rule 134.202 titled Medical Fee Guideline effective August 1, 2003, set out reimbursement guidelines.

1. CPT Code 97799-CP for date of service 06/11/04; payment exception code used was "F, 360 – Non-accredited interdisciplinary program payment reduced 20% below MAR or 20% below usual and customary." The Respondent reimbursed the Requestor $600.00 for 6.5 hours of the Chronic Pain Management Program; according to §134.202(e)(5)(E)(ii) payment shall be $125.00 per hour for CARF accredited programs and 20% below MAR, which is $100.00 per hour, for non-CARF accredited programs. Therefore per the 2002 Medical Fee Guideline an additional reimbursement of $50.00 is due the Requestor.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.201
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 $50.00.**

Ordered by:

	Marguerite Foster	February 24, 2006
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.