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 24361 I-35 East, South, Suite 336 Denton, Texas 76205	MDR Tracking No.: M4-05-9594-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Fireman's Fund Insurance Company C/o Flahive Ogden & Latson Rep Box # 19	Date of Injury: Employer's Name: Pro Group Holdings, Inc. Insurance Carrier's No.: 67099909993

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary states in part, "…The carrier has failed to respond to our initial billing for dates of service 09/13/04, 09/14/04, 09/15/04, and 09/17/04…The carrier failed to respond to our request for reconsideration…"

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 states in part, "…This case involves DOS 09/13/04 through 09/17/04 and has a total amount in dispute of $4,000.00 according to the Requestor. The Requestor fails to show that it timely presented its bills to the carrier. Additionally, carrier has expressly disputed treatment for claimant's degenerative disc disease per its peer, Dr. Singleton…"

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)
08/31/04	No EOBs After CCH 09/16/05	97799-CP-CA (Chronic Pain Management Program) (8 hours)	1-5	$1,000.00
09/14/04	No EOBs After CCH 09/16/05	97799-CP-CA (Chronic Pain Management Program) (8 hours)	1-5	Carrier paid amount. In dispute, minus interest
09/15/04	No EOBs After CCH 09/16/05	97799-CP-CA (Chronic Pain Management Program) (8 hours)	1-5	Carrier paid amount. In dispute, minus interest
09/17/04	No EOBs After CCH 09/16/05	97799-CP-CA (Chronic Pain Management Program) (8 hours)	1-5	Carrier paid amount. In dispute, minus interest
TOTAL DUE				$1,000.00 plus interest for all four dates of service

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. A Contested Case Hearing was held on 09/16/05. It was determined by the Division that, "Injury includes aggravation/acceleration of degenerative disc disease and depression". The diagnoses code documented on the CMS-1500 indicated treatment for 724.2—Lumbago. According to the treatment records provided, Medical Dispute Resolution has determined that the Requestor treated the compensable injury.

2. This dispute relates to CPT code 97799-CP-CA (chronic pain management) for dates of service 09/13/04 (8 hours), 09/14/04 (8 hours), 09/15/04 (8 hours), and 09/17/06 (8 hours). Neither the Requestor nor the Respondent submitted re-audit EOBs per Rule 133.307(d)(2)(B).

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

4. Per updated Table of Disputed Services submitted by Requestor's representative, Lindi Dixon, the Carrier reimbursed a total amount of $3,000.00 for dates of service 09/14/04, 09/15/04 and 09/17/04. The remaining date of service in dispute is 09/13/04.

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 100% of the CARF accredited value.

6. Therefore it is the conclusion of the Division that reimbursement in the amount of $1,000.00 ($125.00 X 8 hours = $4,000.00 - $3,000.00 insurance carrier payment) 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) & (e)(5)(E)
28 Texas Administrative Code Sec. §133.304
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 $1,000.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due for four (4) dates of service 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
		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.