Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: St. Mary's Behavioral Pain Management 3033 Fannin Houston, Texas 77004-3258	MFDR Tracking #: M4-05-A745-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: NORTHSIDE ISD BOX 03	Date of Injury: Employer Name: NORTHSIDE ISD Insurance Carrier #: WC021146919

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary (Table of Disputed Services): "No response to request for reconsideration from carrier."

Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)
3. EOB(s)

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "Please note: Carrier has filed a PN-11 on 9-7-04 – Disputing extent of injury. Please see attached copy of TWCC PLN-11 and also copy of Peer Review."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
9-17-04 – 9-24-04	268	97799-CP	1, 2, 3	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Section §413.011(a-d) titled, *Reimbursement Policies and Guidelines*, and Division Rule 134.202 titled, *Medical Fee Guideline* effective August 1, 2003, sets out the reimbursement guidelines.

1. These services were denied by the Respondent with reason code "268-Entitlement (Non-compensable)."

2. The Respondent has accepted the injury to include "Facial Contusion with associated headaches." The Requestor billed with the Diagnosis Code 346.1 – Common Migraine. These services are compensable and will be reviewed per Rule 134.202(e)(5)(E)(I-ii).

3. The Requestor did not provide a copy of a preauthorization letter. Per Rule 134.600(h)(10(B) Chronic Pain Management requires preauthorization. Reimbursement is not recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.1, §134.202, §134.600

PART VII: DIVISION DECISION AND/OR 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 not entitled to reimbursement for the services involved in this dispute.

DECISION :

	Donna D. Auby	5-25-07
Authorized Signature	Medical Fee Dispute Resolution Officer	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.