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: Active Behavioral Health 2500 W. Freeway #200 Fort Worth, TX 76102	MDR Tracking No.: M4-05-B156-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Texas Mutual Insurance Co. Rep Box #: 54	Date of Injury: Employer's Name: ATRA Corp Insurance Carrier's No.: 99E0000386634

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Requestor's position summary states in part, "Provider sent a request for reconsideration on July 06, 2005. Proof that carrier received request is also included. Carrier chose not to respond within 28 day time frame rule… All Fee guidelines have been followed…"

Principle Documentation:

1. Requestor's position statement
2. CMS 1500
3. EOBs

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Respondent's position summary states in part, "…The requester billed this carrier for date of service 03/23/05. The bill submitted to this carrier indicated Dr. James F. Orr… This carrier denied the charge per TWCC Rule 180.20(a) which states, (a) This section governs the commission's approved doctor list (ADL). Except in an emergency, as defined in §133.1 of this title or for the immediate post-injury medical care, as defined in §180.1 of this title… injured employees shall receive health care from a doctor on the ADL. Dr. Orr was not on the ADL on 03/23/05… Additionally, the requestor was NOT compliant with TWCC Rule 134.304(k) which states, 'If the sender of the bill is dissatisfied with the insurance carrier's final action on a medical bill, the sender may request that the carrier reconsider its action… Upon review, it appears reimbursement was due for date of service 04/07/05…"

Principle Documentation: 1. Position Summary
2. EOBs

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)
03/23/05	18, B7, 224, 287	97799-CP – Chronic Pain Management	1	$00.00
04/07/05	W1, 920	97799-CP – Chronic Pain Management	2	$225.00
TOTAL DUE				$225.00

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 entitled (Medical Fee Guideline) effective August 1, 2003, sets out reimbursement guidelines.

The Respondent states that the requestor was not compliant with TWCC Rule 133.304(k), request for reconsideration. Per Rule 133.307(e)(2)(B) the Requestor submitted a copy of a USPS Return Receipt showing the request for reconsideration was signed by an agent of the Respondent. Therefore, this dispute will be reviewed according to the 2002 Medical Fee Guideline and the Division of Workers' Compensation Rules.

This dispute relates to procedure 97799-CP (Chronic Pain Management Program). For date of service 03/23/05 the insurance carrier denied the services for, "18 – Duplicate Claim/Service; B7 – This provider was not certified/eligible to be

paid for this procedure/service on this date of service; 224 – duplicate charge; and 287 – This service is denied because the doctor is not on the Texas Approved Doctors List (ADL) for this date of service.

The insurance carrier used payment exception codes "W1 – Workers Compensation State Fee Schedule Adjustment and 920 – Reimbursement is being allowed based upon a dispute" for date of service 04/07/04.

1. Per §180.20, review of Division of Workers' Compensation records reveals that the doctor providing the treatment was not on the Approved Doctors List on March 23, 2005. Therefore it is the conclusion of the Medical Review Division that no reimbursement is due for date of service March 23, 2005.

2. Per §134.202(e)(5)(E)(i-ii) 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, the monetary value of the program will be reduced to 80% of the CARF accredited value. Per §134.202(b) documentation supports the level of service billed. Therefore it is the conclusion of the Medical Review Division that additional reimbursement in the amount of $225.00 ($100.00 x 8 hrs. = $800.00 - $575.00) is due.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec.§ 413.011(a-d)
28 Texas Administrative Code Sec. §134.202(b) & (e)(5)(E)
28 Texas Administrative Code Sec. §180.20
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 additional reimbursement **in the amount of $225.00.**

Ordered by:

	Marguerite Foster	November 10, 2205
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.