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: Positive Health Management P O BOX 461606 Garland, Texas 75046-1606	MFDR Tracking #:	M4-07-0017-01
	DWC Claim #:	
	Injured Employee:	
Respondent Name: Federal Insurance Company Box #: 17	Date of Injury:	
	Employer Name:	Cost Plus Inc
	Insurance Carrier #:	006430000883720

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "The explanation of benefits states the denials are based on the following reasons: Unnecessary medical treatment based on peer review; extent of injury, not finally adjudicated. Positive Pain Management disagrees with the denial as documentation attached to the claims supports a multi-disciplinary program…"

Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)
3. EOB(s)
4. Copy of preauthorizations

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: No position summary was submitted to MFDR.

Principle Documentation: The Respondent did not respond to the DWC 60

PART IV: SUMMARY OF FINDINGS

Review of the box 32 on CMS-1500, revealed zip code 77068 is located in Harris county.

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
6-5-06 to 6-9-06	W9	97799-CP-CA (1 hour @ $125.00 X 8 hours x 4 DOS)	1 - 3	$4,000.00
Total Due:				$4,000.00

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.

The Requestor withdrew CPT code 97799-CP-CA billed for dates of service 05-03-06 through 05-17-06.

1. These services were denied by the Respondent with reason code "W9" (Unnecessary medical treatment based on peer review).

2. The Requestor obtained preauthorization (certification number 6193) preauthorizing chronic pain management (15 sessions) for dates of service 05-26-06 to 07-26-06. The Respondent is in violation of Rule 134.600(c)(1)(B) which states in part "The carrier is liable for all reasonable and necessary medical costs relating to the health care: preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care".

3. Reimbursement is recommended per Rule 134.202(e)(5)(E)(i-ii) in the amount of **$4,000.00 (1 hour @ $125.00 x 8 hours = $1,000.00 x 4 DOS).**

A Legal and Compliance referral is made due to the Respondent being in violation of Rule 134.600(c)(1)(B) as referenced in number 2 above.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

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

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. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $4,000.00 plus accrued interest, due within 30 days of receipt of this Order.

ORDER:

		05-24-07
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.