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: Integra Specialty Group, P.A. 517 North Carrier Parkway, Suite G Grand Prairie, TX 75050	MDR Tracking No.: M4-07-0381-01 Claim No.: Injured Employee's Name:
Respondent's Name: American Casualty Company Box 47	Date of Injury: Employer's Name: Jack In The Box Inc Insurance Carrier's No.: 3A827555

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's did not submit a Position Summary; however, requestor's rationale on table of disputed services states, "Pre-Authorized by IRO Review-no # assigned".

Principle Documentation:
1. DWC 60 package
2. CMS 1500's
3. EOBs
4. IRO Notice of Determination

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's did not submit a Position Summary.

Principle Documentation: 1. DWC 60 Response

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)
05/03/06, 05/04/06, 05/10/06	15	97799-CP	1, 2	$2400.00
TOTAL DUE				$2400.00

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. This dispute relates to procedure 97799-CP (Chronic Pain Management) and was denied as "15 - Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider". The Respondent made no payment.

2. The Requestor submitted an IRO Notice of Determination (M2-0860-01 issued on 04/07/06) stating that 20 sessions of chronic pain management were medically necessary; therefore the Respondent denied inappropriately. Per Rule 134.202(e)(5)(A)(ii) and (E)(i -ii) Requestor is not CARF accredited; therefore, reimbursement will be at 80% of the CARF amount. Reimbursement in the amount of $2400.00 ($100.00 x 8 hours x 3 days) is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 413.011(a-d)
28 Texas Administrative Code Sec. §134.1
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 **$2400.00**. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30-days of receipt of this Order.

Ordered by:

	Scott Hansen	11/14/06
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.