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: Priority Pain Relief Center/Gregory D. Davidovich, D.C. 680 N. Carroll Ave, Ste. 120 Southlake, TX 76092	MDR Tracking No.: M4-07-1045-01 Previous Tracking No.: M4-06-1250-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name: American Casualty Company of Reading Box: 47	Date of Injury:
	Employer's Name: American National Insurance Company
	Insurance Carrier's No.: 3C039537

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary states in part, "Dates of service in question were pre-authorized".

Principle Documentation: 1. DWC 60 package
2. CMS 1500's
3. EOBs
4. Pre-Authorization Letters

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary states in part, "Carrier has denied the right to reimbursement because of a pending extent of injury dispute".

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)
1/11/05	R	97750-FC (4 hours)	1,3	$447.00
1/24/05, 1/25/05, 1/27/05, 1/28/05, 1/31/05, 2/01/05, 2/02/05, 2/07/05, 2/08/05, 2/09/05, 3/07/05, 3/08/05	R, W12, W4	97799-CP ($100 x 93 hours)	1,2,3,4	$9,300.00
TOTAL DUE				$9,747.00

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. CPT code 97750-FC (Functional Capacity Evaluation), was denied as "R – Extent of injury" for date of service 1/11/05, CPT code 97799-CP (Chronic Pain Management), was denied as "R and W12 – Extent of injury" for dos-1/24/05-3/08/05 and "W4 – No additional reimbursement allowed after review of appeal/reconsideration".

2. Per CCH Decision dated 5/30/06, it was determined by the Contested Case Hearing Officer that the Claimant's injury of ___ extends to chronic pain syndrome after May 2005. According to the CMS-1500's, the treatment rendered, per diagnosis codes used, were as follows: 722.0 – Cervical Disc Displacement, 722.10 – Displacement Lumbar Disc Without Myelopath, 724.2 – Lumbago and Cervicobrachial Syndrome. The services provided were for the compensable injury to the cervical & lumbar spine.

3. Per Rule 134.600(h)(10)(B), the Requestor submitted pre-authorization approval #1394753 for (10) sessions of Chronic Pain Management, with a start date of 1/13/05, and an ending date of 3/31/05. The Requestor also submitted pre-authorization approval #1423553 for (10) additional sessions of Chronic Pain Management, with a start date of 2/18/05, and an ending date of 4/30/05.

4. Per Rule 134.202(e)(4)(c)(1), FCE's shall be reimbursed for up to a maximum of four hours for the initial test. Therefore, per Rule 134.202(b) and (c)(1), recommend reimbursement of $447.00.

5. 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 $9,300.00 ($100.00 x 93 hours) 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
28 Texas Administrative Code Sec. §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 additional reimbursement in the amount of **$9747.00**. 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.

Decision by:

	Scott Hansen, Medical Dispute Officer	12/11/06
Authorized Signature	Typed Name	Date

Ordered by:

	Margaret Ojeda, Manager	12/11/06
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.