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

Pinnacle Pain Management 2100 Bering #809 Houston, Texas 77057	MFDR Tracking #: M4-07-1084-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: NEW HAMPSHIRE INSURANCE CO BOX 19	Date of Injury: Employer Name: CORRECTIONAL SERVICES INC Insurance Carrier #: 710153508

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary (Table of Disputed Services): "Pre-Auth obtained by AIGS."

Principle Documentation:

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

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "…The carrier contends that the treatments underlying the charges in dispute were for body parts and/or conditions not related to the compensable injury…There has been no final resolution of this liability dispute."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Review of the box 32 on CMS-1500, revealed zip code 77057 is located in Harris County.

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
11-7-05 – 12-05-05	W2, W4	90808	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.

A Revised Table of Disputed Services was submitted on 5-10-07. This Table will be used for this review.

1. These services were denied by the Respondent with reason code "1, W2-Workers' compensation claim adjudicated as non-compensable. Carrier not liable for claim or service/treatment," and "1-W4-No additional reimbursement allowed after review of appeal/reconsideration."

2. Per a Contested Case Hearing Ruling on 2-20-07, the compensable injury extends to include bilateral shoulder sprain/strain, right shoulder tendonitis, right shoulder full thickness tear of the supraspinatus, tendon and left ankle s/s/ Diagnoses codes which were billed by the doctor are 724.2 – lumbago and 719.46 – pain in joint, lower leg, 719.47 – joint pain-ankle and 724.5 – unspecified backache. This injury is compensable.

3. Per Rule 134.202 this procedure is considered to be a component procedure of 90880 which was billed on this date of service. The services represented by the code combination are not paid separately. Recommend no reimbursement.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

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

PART VII: DIVISION DECISION

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	5-24-07
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.