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: NORTH TEXAS PAIN RECOVERY CENTER 6702 WEST POLY WEBB RD ARLINGTON TX 76016-3615	MFDR Tracking #: M4-07-3366-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: TASB RISK MGMT FUND BOX 47	Date of Injury: Employer Name: CEDAR HILL ISD Insurance Carrier #: 0250011041812772

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary (Table of Disputed Services): "Medically Necessary."

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 service dated July 14, 2006 was denied as not allowed at time of pre-authorization. This would have been the sixth visit with five having been authorized."

Principle Documentation:

1. Response to DWC 60
2. EOB(s)

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
7-14-06	39	97799-CP-CA ($125.00 x 8 hours)	1, 2	$1,000.00
Total Due:				

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.

1. These services were denied by the Respondent as "39-Services denied at the time authorization/pre-certification was requested."

2. The Preauthorization Letter # HICK06282006001, dated 7-5-06, authorized 5 days of Chronic Pain Management Program. These services were rendered on 7-10-06, 7-11-06, 7-12-06, 7-13-06 and 7-14-06. The carrier did not reimburse the Requestor for date of service 7-14-06.

3. Per Rule 134.202(e)(5)(E) the Chronic Pain Management Program shall be reimbursed at $125.00 per hour for a CARF accredited program. Recommend additional reimbursement in the amount of $1.000.00.

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 AND/OR 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 $1.000.00 plus accrued interest, due within 30 days of receipt of this Order.

ORDER:

	Donna Auby	5-22-07
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.