Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
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 2301 Forest Lane # 312 Garland, Texas 75042	MFDR Tracking #: M4-07-5178-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: American Motorists Insurance Box 42	Date of Injury: Employer Name: Alcon Laboratories Inc. Insurance Carrier #: 460CM047483N

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "Positive Pain Management disagrees with the denial as documentation attached to the claims supports a multi-disciplinary program. Medical necessity of the chronic pain program was addresses when pre-authorization was requested and granted for the Chronic Pain Management Program. Preauthorization number 4003848 was obtained from Broadspire for the Chronic Pain Management Program. Approval granted in accordance with Rule 134.600(H)."

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: The Respondent did not submit a position summary to MFDR.

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
9-25-06 to 11-13-06	W1, W4, W9, 147, 45	97799-CP-CA	1 - 4	Reimbursement recommended per the contract between the Requestor and Respondent when services rendered.
Total Due:				SEE ABOVE

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 with reason codes "W9" (Unnecessary medical treatment based on peer review), "W1" (Workers Compensation State Fee Schedule Adjustment), "W4" (No additional reimbursement allowed after review of appeal/reconsideration), "147" (Provider contracted/negotiated rate expired or not on file) and "45" (Charges exceed your contracted/legislated fee arrangement).

2. The Requestor was contacted and verified that a contract did exist between the Requestor and Respondent. The Respondent has not made a payment to the Requestor. Preauthorization was obtained by the Requestor prior to the services being rendered (preauthorization number 4003848) initially authorizing 10 sessions (8 hours a day, five days a week for two weeks) of Chronic Pain Management as an outpatient and subsequently authorizing an additional 10 sessions (8 hours a day, five days a week for two weeks) of Chronic Pain Management as an outpatient. 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. Per review of Box 32 on CMS-1500 zip code 77068 is located in Harris County.

4. Reimbursement is recommended per the contract between the Requestor and Respondent when the services were rendered.

A Legal and Compliance referral is made due to the Respondent being in violation of Rule 134.600(c)(1)(B) 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 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 reimbursement per the contract between the Requestor and Respondent when services rendered plus accrued interest, due within 30 days of receipt of this Order.

ORDER:

		06-21-07
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.