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:	
Chronic Pain Recovery Center 25810 Oakridge Drive The Woodlands, Texas 77380	MFDR Tracking #: M4-07-5908-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: ACE INSURANCE CO OF TEXAS BOX 15	Date of Injury: Employer Name: STEIN MART INC Insurance Carrier #: C290C982178X

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "The injured worker suffered a documented injury, she was referred to the Chronic Pain Recovery Center by her treating physician and all services were preauthorized and deemed medically necessary by the peer doctors at the Carrier's preauthorization company. We feel that all Workers' Compensation guidelines have been satisfied."

Principle Documentation:

1. DWC 60 package
2. Total amount sought - $13,600.00
3. CMS 1500(s)
4. EOB(s)
5. Preauthorization letters

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

No Position Summary was received from the Respondent.

Principle Documentation:

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

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	CPT Code(s) and Calculations	Part V Reference	Amount in Dispute*	Ordered Amount
5-11-06 – 6-16-06	97799-CP ($100.00 x 8 hrs x 15 units)	1, 2, 3	$12,000.00	$12,000.00
Total Due:				$12,000.00

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.

The request for medical fee dispute resolution was filed on 5-11-07 and that date is after the 365 days allowed per Rule 133.307, for filing the request for all services except those listed in Part IV above. *The "Amount in Dispute" column in Part IV does not address amounts sought for services that were not timely disputed.

The Requestor faxed a Revised Table of Disputed Services on 7-24-07. This Table will be used for this review. The Requestor stated, "The Respondent has made a partial payment of the disputed service…In all, four dates of service (June 8, 2006, June 9, 2006, June 19, 2006 and June 20, 2006) were paid in full."

1. These services were denied by the Respondent with reason code "W9-Unnecessesary medical treatment based on peer review," "W1-598-The reimbursement for this procedure has been calculated according to the guidelines for

a program that is not CARF accredited," and/or "W1-663-Reimbursement has been calculated according to state fee schedule guidelines."

2. Per Rule 134.600 (c)(1)(B) the Requestor provided a copy of preauthorization letters dated 4-24-06, 5-17-06, and 6-12-06 for 21 sessions of chronic pain management. The Respondent denied these sessions for unnecessary medical treatment based on a peer review. Per 134.600 (c)(1)(B) "The carrier is liable for all reasonable and necessary medical costs relating to the health care that was approved prior to providing the health care."

3. Per Rule 134.202(e)(5)(E) the Chronic Pain Management Program shall be reimbursed at $100.00 per hour for a Non-CARF accredited program. Reimbursement is recommended.

A Legal and Compliance referral has been made for inappropriate denial of the preauthorized service per Rule Per 134.600 (c)(1)(B).

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.1, §134.202, §134.600

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, section §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 $12,000.00 plus applicable accrued interest per Division Rule 134.803 due within 30 days of receipt of this Order.

ORDER:

	Donna D. Auby	
	Medical Fee Dispute Resolution Officer	
	Amy Rich	
Authorized Signature	Medical Fee Dispute Resolution Director	Date

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812