Amended MDR Tracking Number: M4-03-8422-01 **(Previously M4-03-0900-01)**

This amended Findings AND Decision supercedes all previous decisions rendered in this medical payment dispute involving the above Requestor and Respondent.

The Medical Review's decision of June 12, 2003 was appealed and subsequently withdrawn by an order of the Medical Review Division dated July 9, 2003.

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above. This dispute was received on 11/18/02.

I. DISPUTE

Whether there should be **additional** reimbursement of $4,827.25 for Chronic Pain Management for dates of service 3/14/02 through 5/8/02. The Respondent denied additional reimbursement as "F – Reduced According to Fee Guideline".

II. RATIONALE

In the withdrawn Decision and Order there was a misconception of the existence of the –75 modifier. This file will be reviewed using the CPT code 97799-CP-75 as submitted by the Requestor.

The Respondent denied the above dates of service as "F" Reduced According to Fee Guideline. There is no MAR value for 97799-CP-75. Pursuant to Rule 133.304 (c) the Carrier is required to use the correct payment exception code when denying services. The Respondent's denial on the EOB is not the same as the explanation in the position statement. Based on Rule 133.307 (j)(2), the only issue raised before the date medical dispute resolution was requested and to be considered in this review, is the denial code of "F".

The Requestor is a non-CARF facility. The Requestor billed 165 units at $195.00 an hour for a total of $32,175.00. The Respondent paid $20,913.75. According to the Requestor's Table of Disputed Services the amount in dispute is $4,827.25. A 20% reduction has been taken for a non-CARF facility. **Reimbursement** is recommended.

III. DECISION & ORDER

Based upon the review of the disputed healthcare services within this request, the Medical Review Division has determined that the requestor **is** entitled to reimbursement for the referenced CPT code in the amount of **$4,827.25.** Pursuant to Sections 402.042, 413.016,

413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit **$4,827.25** plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this Order.

The above Findings, Decision and Order are hereby issued this 16th day of July 2003.

Supervisor, Manager or Director
Medical Dispute Resolution Officer
Medical Review Division

Medical Dispute Resolution
Medical Review Division