

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x)HCP ()IE ()IC	Response Timely Filed? (x)Yes ()No
Requestor's Name and Address Princeton Pain Management 3500 Oak Lawn Suite 380 Dallas TX 75219	MDR Tracking No.: M5-04-3204-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address c/o FOL Box 39	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
5-23-03	7-31-03	99245, 90899, 97750, 97799-CP	\$4,794.50	\$201.00

PART III: REQUESTOR'S POSITION SUMMARY

Letter dated 5-19-04 states, "...our position for reimbursement was clearly outlined in the letter to the carrier dated 4-29-04. A copy of that correspondence is included with this submission..." Letter dated 4-29-04 to carrier states, "...Per EOB's received from your company, these services were incorrectly paid. Correctly paid dates of service are intermingled with these dates not correctly paid..."

PART IV: RESPONDENT'S POSITION SUMMARY

Letter dated 6-7-04 states, "For date of service 5-23-03, the dispute is for an office consultation under CPT 99245. Provider has failed to justify through documentation that that level of care was appropriate or rendered on this case... Date of service 5-23-03 also includes a dispute billing under CPT 90899 for preparation of a psychiatric report. The service has not been documented. Date of service 6/13/03 involves a dispute of a functional capacity evaluation under CPT 97750... Functional capacity evaluations had previously been performed and billed for dates 12/6/02, 12/19/02, 12/23/02, 1/2/03, 1/8/03, 1/22/03, 2/3/03, 2/12/03, 2/17/03, and 4/23/03. For dates of service 7/15/03 to 7/31/03, the dispute concerns Chronic Pain Management services billed under CPT 97799CP. The 1996 Medical Fee Guidelines do not set a MAR for this service. Medicare has not adopted a fee reimbursement for chronic pain management. .. 28 TAC 133.202, effective for dates of service after 9/1/03, sets reimbursement at a level of \$125.00 per hour unit. The reimbursement in this case has been calculated at a rate of \$100.00 per unit..."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

9245 billed on 5-23-03 was denied as GL6A – follow-up visits in the consultant's office should be reported as established patient office visit code. The consultation note does not indicate that this was a follow-up visit. Per the 1996 MFG, E/M ground rule IX, A and D.1, recommend reimbursement of \$201.00.

Code 90889 billed on 5-23-03 was denied as TR45 (N) – for payment consideration, please provide a description of the procedure/service. This code is for an unlisted psychiatric service and is a DOP code. Per the 1996 MFG, general instructions, III, the DOP requirements have not been met. Documentation submitted was incomplete. A Pain Disability Index Questionnaire was dated 5-23-03 however, all pages did not have a name and/or date. No reimbursement recommended.

97750-FC billed on 6-13-03 was denied as TX27 – per the Texas fee guideline, FCEs may be billed three times per injured worker. The carrier submitted copies of previous FCEs billed on 12-6-02, 12-19-02, 12-23-02, 1-2-03, 1-8-03, 1-22-03, 2-3-

03, 2-12-03, 2-17-03, and 4-24-03. The MFG guidelines have been exceeded, therefore, no reimbursement recommended.

97799-CP billed on 7-15-03, 7-16-03, 7-18-03, 7-21-03, 7-29-03, 7-30-03, and 7-31-03 was denied as DOP (M) – reimbursed per the carrier @ fair and reasonable. The carrier paid \$100.00 per hour on each date of service. Texas Labor Code 413.011 (d), Commission Rule 133.307 (g)(3)(D) and Rule 133.304 (i) (1-4) places certain requirements on the Carrier when reducing the services for which the Commission has not established a maximum allowable reimbursement. The Respondent is required to develop and consistently apply a methodology to determine fair and reasonable reimbursement and explain and document the method used for the calculation. The Respondent submitted a methodology as follows: “The 1996 Medical Fee Guidelines do not set a MAR for this service. Medicare has not adopted a fee reimbursement for chronic pain management. .. 28 TAC 133.202, effective for dates of service after 9/1/03, sets reimbursement at a level of \$125.00 per hour unit. The reimbursement in this case has been calculated at a rate of \$100.00 per unit...”. The requestor billed \$195.00 per hour on each date of service and the carrier reimbursement \$100.00 per hour on each disputed date of service.

Per Rule 133.307(g)(3)(D), the Requestor is also required to discuss, demonstrate and justify that the payment being sought is a fair and reasonable rate of reimbursement. The Requestor did not provide sample EOBs or other documentation as evidence that the fees billed are for similar treatment of injured workers and that reflect the fee charged to and paid by other carriers.

The Respondent in this case has provided an adequate methodology as required by the rule and the Requestor has not sufficiently justified its request for additional reimbursement. Therefore, no additional reimbursement is recommended.

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to reimbursement in the amount of \$201.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Dee Z. Torres

8-22-05

Authorized Signature

Typed Name

Date

PART VIII: YOUR RIGHT TO REQUEST A HEARING

If you are unhappy with all or part of this decision, you have the right to appeal the decision. Those who wish to appeal decisions that were issued during the month of August 2005, should be aware of changes to the appeals process, which take effect September 1, 2005.

House Bill 7, recently enacted by the 79th Texas Legislature, provides that an appeal of a medical dispute resolution order that is not pending for a hearing at the State Office of Administrative Hearings (SOAH) on or before August 31, 2005 is not entitled to a SOAH hearing. This means that the usual 20-day window to appeal to SOAH, found in Commission Rule 148.3, will be shortened for some parties during this transition phase. If you wish to seek an appeal of this medical dispute resolution order to SOAH, you are encouraged to have your request for a hearing to the Commission as early as possible to allow sufficient time for the Commission to submit your request to SOAH for docketing. A request for a SOAH hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas 78744 or faxed to 512-804-4011. A copy of this Decision should be attached to the request.

Beginning September 1, 2005, appeals of medical dispute resolution 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.

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

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____