



MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address: Integra Specialty Group, P. A. 517 North Carrier Parkway, Suite G Grand Prairie, TX 75050	MDR Tracking No.: M5-05-3248-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: National Fire Insurance, Box 47	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The carrier pre-authorized 10 sessions of chronic pain management. The carrier did not reimburse the total amount for date of service 10-14-04.

In a letter dated 8-23-05 the requestor withdrew all items denied for medical necessity which were dates of service 9-1-04 through 10-28-04 with the exception of 10-14-04.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's position letter states that the carrier already reimbursed the provider \$300 for date of service 10-14-04. It states that the carrier's rate of reimbursement is consistent with the Fee Guidelines for reimbursement of a chronic pain management program that is not CARF accredited.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
10-14-04	8 units of CPT code 97799-CP	1	\$500.00

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

1. Per Rule 134.202(e)(5)(E) reimbursement for non-CARF accredited Chronic Pain Programs shall be 80% of \$125.00 per hour for a total of \$100.00 per hour. The requestor billed 8 units. The carrier has reimbursed 3 units.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 134.202(e)(3)

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 additional reimbursement in the amount of \$500.00. 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 30-days of receipt of this Order.

Ordered by:

Donna Auby

9-15-05

Authorized Signature

Typed Name

Date of Order

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). 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. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

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