



MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: Health Care Provider Injured Employee Insurance Carrier

Requestor's Name and Address:

Buena Vista Workskills
 5445 La Sierra Dr. #204
 Dallas, Texas 75231

MDR Tracking No.: M5-06-0406-01

Claim No.:

Injured Employee's Name:

Respondent's Name and Address:

Zurich American Insurance Company, Box 19

Date of Injury:

Employer's Name:

Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documentation:

1. Position Summary stating, "The Chronic Pain Management Program claims were paid below MAR."
2. DWC 60 packet
3. Preauthorization letters

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documentation:

1. Position Summary stating, "Carrier asserts that it has issued reimbursement at an appropriate rate."
2. DWC 60 packet

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	Denial Code	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
11-29-04 – 1-26-04	W9	CPT code 97799 CP-CA	1, 2	\$795.32
Total Due				\$795.32

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

1. Per Rule 134.202(e)(5)(E) reimbursement for CARF accredited Programs shall be \$125.00 per hour. Carrier has reimbursed \$4,735.93. Additional amount due is \$795.32.
2. The carrier denied these sessions for unnecessary medical treatment based on a peer review. Rule 133.301 (a) states "the insurance carrier shall not retrospectively review the medical necessity of a medical bill for treatments (s) and/or service (s) for which the health care provider has obtained preauthorization under Chapter 134 of this title."

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. § 413.011(a-d)
28 Texas Administrative Code Sec. §134.1 and §134.202(e)(5)(E) and §133.301.

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 \$795.32.**

Ordered by:

Donna Auby

12-05-05

Authorized Signature

Typed Name

Date of Order

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.