



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: Injury One Treatment Center 5445 La Sierra Dr., Suite 204 Dallas, Texas 75231	MDR Tracking No.: M5-06-1065-01 Previous No.: M5-05-2923-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Insurance Company of the State of PA, Box 19	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 package. Position summary states, "This patient's recovery would have been negatively impacted without these treatments."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 response. Position summary states, "Carrier has reviewed the bills and will reimburse provider according to the Medical Fee Guideline."

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)
7-7-04, 7-9-04, 7-12-04, 7-13-04, 7-14-04, 7-15-04, 7-16-04, 7-19-04, 7-27-04, 7-28-04, 7-29-04, 7-30-04, 8-2-04, 8-10-04, 8-11-04	No EOB's	CPT code 97799-CP-CA (Per Rule 134.202(e)(5)(E) MAR is \$125.00 per hour.)	1, 2	\$125 X 120 hours = \$15,000.00
7-8-04, 7-21-04, 7-23-04, 7-26-04, 8-3-05, 8-4-05, 8-5-04	V	CPT code 97799-CP-CA CPT code 97799-CP-CA (Per Rule 134.202(e)(5)(E) MAR is \$125.00 per hour.)	1, 3	\$125 X 45 hours = \$5,625.00
7-21-04, 7-22-04	U	CPT code 97799-CP-CA CPT code 97799-CP-CA (Per Rule 134.202(e)(5)(E) MAR is \$125.00 per hour.)	1, 3	\$125 X 16 hours = \$2,000.00
7-20-04	R	CPT code 97799-CP-CA CPT code 97799-CP-CA (Per Rule 134.202(e)(5)(E) MAR is \$125.00 per hour.)	1, 4	\$125 X 1 hour = \$1,000.00
Total Due				\$23,625.00

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

1. Per Rule 134.600 (h) (4), the requestor sent a copy of preauthorization letters dated 6-30-04, 7-15-04 and 7-29-04 for 30 sessions of chronic pain management.
2. Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's per rule 133.307(e)(3)(B). The respondent was contacted numerous times. No additional EOB's were received.

3. 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." A Compliance and Regulations referral will be made for inappropriate denial of the preauthorized service.
4. One date of service was denied as "R-Extent of injury". In a Benefit Review Conference held on 11-10-05 the parties agreed that the "compensable back injury of 5-28-03 does not extend to include the claimant's left ankle." The primary diagnosis codes on the CMS 1500's are for the back, however, they also include the diagnosis code 845.0 which is "ankle sprain/strain." It is impossible to break up the charges for Chronic Pain Management.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. § 413.011(a-d)
 28 Texas Administrative Code Sec. §134.1, Rule 133.301 (a), 133.307(e)(2)(B), 133.307(e)(3)(B), 134.600 (h) (4)

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 **\$23,625.00**.

Findings and Decision by:

Donna Auby, Dispute
 Resolution Officer

06/07/2006

Ordered by:

Date of Finding and Decision

Amy Rich, Director Medical
 Dispute Resolution

06/07/2006

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.