



## MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

### PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (x) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address: Canton Healthcare Systems 300 S. Main St. Canton, TX 75103	MDR Tracking No.: M5-06-2150-01
Respondent's Name and Address:  Rep Box #43	Claim No.:
	Injured Employee's Name:
	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

### PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: "...George Esterly worked with this patient for Chronic Pain Management, and pre-authorization was received on all dates of service; ... An adjuster is not licensed to make independent medical necessity determinations, and likewise cannot supercede the determinations of the audit company's licensed providers; ... We treated the patient in good faith, and expect to be reimbursed for our services..."

Principle Documentation:

1. DWC 60/Table of Disputed Services
2. Requestor's position statement
3. CMS 1500's
4. EOB's

### PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: "...This Claim has involved compensable and extent of injury issues and has been through the Benefit Dispute Process. As a result of a contested case hearing, the Hearing Officer determined that the compensable injury includes a disc bulge at spinal level L4-5 but did not include any other damage or harm to the Claimant's spine. The Hearing Officer further noted that the compensable injury does not include an injury to the urinary tract infection, incontinence, bruising of the renal collection system/kidney, degenerative disc disease in the cervical, thoracic and lumbar spine, or disc desiccation from spinal levels L1 – L5. It remains the Carrier's position that the proposed treatment at issue was not reasonable or necessary to treat the compensable injury, which based on the Hearing Officer's decision is limited to the disc bulge at L4-L5 and does not include the other conditions maintained by the injured worker. Furthermore, the Carrier disputes that the services actually provided were pain management services..."

Principle Documentation: 1. Carrier's Response

### 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)
08-11-04	F, W4	97799-CP	1,2,3	\$800.00
08-16-04, 08-18-04, 08-20-04 09-08-04 through 09-10-04 09-14-04 through 09-17-04	U, 244, R, 1003	97799-CP x 9 DOS	2,4,5,6,7,8	\$7,200.00
08-19-04 08-23-04 through 08-26-04 09-20-04 through 09-22-04	U, 244, W4, W12	97799-CP x 7 DOS	2,4,5,6,7,8	\$5,600.00

08-30-04	U, 244	97799-CP	9, 10	\$0.00
09-13-04	F, U, D, 247	97799-CP	2,5,11	\$800.00
TOTAL DUE				\$14,400.00

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

Section 413.011(a-d) titled (Guidelines and Medical Policies), and Division Rule 134.202 titled Medical Fee Guideline effective August 1, 2003, set out reimbursement guidelines.

1. The Requestor billed CPT code 97799-CP for DOS 08-11-04. The Respondent's EOB denial asserts: "F-Fee Guideline Maximum Allowable Reimbursement Reduction" with a recommended allowance of \$680.00; the reconsideration EOB denial asserts: "W4-no additional reimbursement allowed after review of appeal/reconsideration."
2. According to Rule 134.202(e)(5)(i-ii) the MAR for a Chronic Pain Program (CPM) shall be \$125.00 per hour for a CARF accredited program. A CARF accredited program for CPM is indicated by using the modifier -CA. The Requestor did not provide the CARF accredited modifier; therefore, the monetary value of the program will be reduced to \$100.00 (80% of the CARF accredited value.)
3. Per Rule 134.202(e)(5)(i-ii), recommend reimbursement for DOS 08-11-04 in the amount of \$800.000. (\$100.00x8/units)
4. The Requestor billed CPT code 97799-CP for DOS 08-16-04, 08-18-04, 08-20-04, 09-08-04 through 09-10-04 and 09-14-04 through 09-17-04. Respondent's EOB denials assert: "U/ 244-Unnecessary Medical (w/o peer review); the reconsideration EOB denial asserts: R-Extent of Injury and 1003- In response to your appeal of our previous re-evaluation, no significant additional documentation or information regarding this claim has been received. Our position remains unchanged on the same questions that were previously posed by the provider. Therefore, no additional allowance is recommended."
5. Per Rule 133.301(a) in effect at the time services were rendered, the insurance carrier may not retrospectively review the medical necessity of a medical bill for treatments/services that the health care provider has obtained preauthorization. The Requestor received preauthorization for CPM. The preauthorization numbers for CPM are: #31420 for DOS 08-11-04 through 08-30-04 and #31663 for DOS 09-08-04 through 09-22-04.
6. The CCH of June 8, 2006 concludes that the compensable injury of \_\_\_\_\_ includes a bulging disc and radiculopathy and radicular symptoms at L4-5 as a result of that injury. Requestor billed for services using diagnosis codes 722.93- Other and unspecified disc disorder (lumbar), 724.2- Spinal stenosis, other than cervical (lumbago) and 724.5- Spinal stenosis, other than cervical (Backache, unspecified).
7. The Requestor billed CPT code 97799-CP for DOS 8-19-04, 08-23-04 through 08-26-04 and 09-20-04 through 09-22-04. The Respondent's EOB denials assert: "U/ 244-Unnecessary Medical (w/o peer review); the reconsideration EOB denial asserts: W4-No Additional Reimbursement allowed after review of appeal /reconsideration, and W12-Extent of injury. Not finally adjudicated."
8. Therefore, per rule 134.202(e)(5)(i-ii) recommend reimbursement of \$100.00/hour x 8 hours x 16 DOS:
  - For DOS 08-16-04 recommend reimbursement of \$800.00
  - For DOS 08-18-04 recommend reimbursement of \$800.00
  - For DOS 08-19-04 recommend reimbursement of \$800.00
  - For DOS 08-20-04 recommend reimbursement of \$800.00
  - For DOS 08-23-04 recommend reimbursement of \$800.00
  - For DOS 08-25-04 recommend reimbursement of \$800.00
  - For DOS 08-26-04 recommend reimbursement of \$800.00
  - For DOS 09-08-04 recommend reimbursement of \$800.00
  - For DOS 09-09-04 recommend reimbursement of \$800.00
  - For DOS 09-10-04 recommend reimbursement of \$800.00
  - For DOS 09-14-04 recommend reimbursement of \$800.00
  - For DOS 09-16-04 recommend reimbursement of \$800.00
  - For DOS 09-17-04 recommend reimbursement of \$800.00
  - For DOS 09-20-04 recommend reimbursement of \$800.00
  - For DOS 09-21-04 recommend reimbursement of \$800.00
  - For DOS 09-22-04 recommend reimbursement of \$800.00

9. Requestor billed CPT code 97799-CP for DOS 08-30-04. The Requestor only submitted the initial EOB. The Respondent's EOB denial asserts: "U, 244-Unnecessary treatment (w/o peer review)."
10. The Requestor did not submit convincing evidence of their request for reconsideration to the Respondent per Rule 133.307(e)(2)(B). Therefore, cannot recommend reimbursement.
11. The Requestor billed CPT code 97799-CP for DOS 09-13-04. The Respondent's EOB denials assert: "F-Fee Guideline maximum allowable reimbursement reduction; the reconsideration EOB denial asserts: U-Unnecessary treatment (without peer review), D-Duplicate bill and 247-This appears to be a duplicate charge. Per rule Per Rule 134.202(e)(5)(i-ii) reimbursement is recommended in the amount of \$800.00. (\$100.00 x 8)

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION**

Texas Labor Code Sec. §413.011(a-d)  
 28 Texas Administrative Code Sec. §134.1  
 28 Texas Administrative Code Sec. §134.202  
 28 Texas Administrative Code Sec. §134.307  
 28 Texas Administrative Code Sec. §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 \$14,400.00** plus all accrued interest due at the time of payment to the Requestor within 30 days of receipt of this Order.

Ordered by:

10-10-06

\_\_\_\_\_  
 Authorized Signature

\_\_\_\_\_  
 Typed Name

\_\_\_\_\_  
 Date of Order

Decision by:

\_\_\_\_\_  
 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.**