**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

PAIN AND RECOVERY CLINIC
6660 AIRLINE DRIVE
HOUSTON TX 77076

**Respondent Name**
TASB RISK MGMT FUND

**Carrier's Austin Representative Box**
Box Number 47

**MFDR Tracking Number**
M4-08-0322-02

**MFDR Date Received**
OCTOBER 31, 2007

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "The injury sustained by [Claimant] is in the process of being resolved."

**Amount in Dispute:** $2,900.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The claimant was notified in January that [redacted] was disputed. The provider was notified in the preauthorization letter that the dispute existed. Medical necessity for treatment is the only thing the preauthorization is based on, not whether the treatment is compensable. Compensability, according to the rule, is not to be considered when determining if treatment is medically necessary for the condition being treated. As a result, TASB feels our decision regarding services rendered by Pain & Recovery Clinic is valid and we are standing by that decision."

**Response Submitted by:** TASB

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| May 7, 2007 | Chronic Pain Management Services<br>CPT Code 97799-CP | $100.00 | $0.00 |
| May 14, 2007<br>May 16, 2007<br>May 30, 2007<br>May 30, 2007 | Chronic Pain Management Services<br>CPT Code 97799-CP | $700/day X4<br>= $2,800.00 | $0.00 |
| TOTAL | | $2,900.00 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.

3. 28 Texas Administrative Code §134.202, titled *Medical Fee Guideline* effective for professional medical services provided on or after August 1, 2003, set out the reimbursement guidelines.
4. 28 Texas Administrative Code §141.1 sets out the procedures for requesting and setting a Benefit Review Conference.
5. EOBs submitted with the requestor's dispute indicate the respondent has raised issues of Compensability, Extent, and/or Liability for dates of service May 14, 2007 through May 30, 2007.
6. The EOBs indicate that the respondent paid $600.00 for chronic pain management services rendered on May 7, 2007 based upon "W1-Workers Compensation State Fee Schedule Adjustment. Per TWCC MFG, non-CARF Accredited facilities receive a 20% reduction. Documentation attached supports 6 hours of attendance."

**Issues**

1. Does the documentation support the seven hours of chronic pain management services billed for May 7, 2007? Is the requestor entitled to additional reimbursement?
2. Did the requestor file for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.305 and §133.307 for dates of service May 14, 2007 through May 30, 2007?
3. Is the requestor eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307 for dates of service May 14, 2007 through May 30, 2007?

**Findings**

1. According to the explanation of benefits, the respondent paid six hours of CPT code 97799-CP rendered on May 7, 2007 based upon the fee guideline. The seventh hour of CPT code 97799-CP was denied based upon the documentation did not support number of hours billed in the chronic pain management program. The Division reviewed the submitted documentation and finds the following:

| REPORT | SESSION TIME | TOTAL HOURS |
|---|---|---|
| Behavioral Chronic Pain Management Group Session Monitoring Form | 9:00-11:00 | 2 |
| Behavioral Chronic Pain Management Group Session Monitoring Form | 11:00-1:00 | 2 |
| Massage Therapy Session | Not Listed | Not Listed |
| Chronic Pain Management Program Daily Activity Sheet | Not Listed | 2 |

   The Division reviewed the documentation and finds that the requestor only listed six hours of chronic pain management. The requestor did not list the time in the Massage Therapy Session. In addition, the requestor's documentation does not reflect any breaks or lunch time. Because the total time for massage was not listed, additional reimbursement is not recommended.
2. The requestor filed a dispute with the Medical Fee Dispute Resolution section at the Division on October 31, 2007.

   According to 28 Texas Administrative Code §133.305(a)(4), a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) goes on to state that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." 28 Texas Administrative Code §133.307(e) (3) (H) requires that if the carrier has raised a dispute pertaining to compensability, extent of injury, or liability for the claim, the Division shall notify the parties of the review requirements pursuant to §124.2 of this title, and will dismiss the request until those disputes have been resolved by a final decision, inclusive of all appeals. The appropriate dispute process for unresolved issues of compensability, extent and/or liability requires filing for a Benefit Review Conference pursuant to 28 Texas Administrative Code §141.1 prior to requesting medical fee dispute resolution. No documentation was submitted to support that the issue(s) of compensability, extent and/or liability have been resolved as of the undersigned date.
3. The requestor has failed to support that the disputed services rendered from May 14, 2007 through May 30, 2007 are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

**Conclusion**

For the reasons stated above, the requestor has failed to establish that the respondent's denial of payment reasons concerning liability for the injured employee's workers' compensation claim, compensability of that claim, and/or extent-of-injury issues with that claim have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 410 prior to the submission of a medical fee dispute request for the same services. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute. As a result, no amount is ordered.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

**Authorized Signature**

| | | |
|---|---|---|
| | | 2/28/2014 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

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