Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address:	MFDR Tracking #: M4-11-0224-01
COMPREHENSIVE PAIN MANAGEMENT 5734 SPOHN DRIVE STE. A CORPUS CHRISTI, TX 78414	DWC Clai Injured Er
Respondent Name and Box #:	Date of In
WAL MART ASSOCIATES INC Box #: 53	Employer Na Insurance Carri

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier denied claim for "165-payment denied/reduced for absence of, or exceeded referral and 5066-not treating doctor approved treatment". Claim was appealed. Request for reconsideration sent. Claim was denied again with reason code "193-original payment decision is being maintained. This claim was processed properly the first time, 165-payment denied/reduced for absence of, or exceeded referral, 5081-reduction or denial of payment resulting after a reconsideration was completed, 5066-not treating doctor approved treatment, and 1014-the attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted. Patient came in on 05/27/10 for an office follow up visit. A patient follow up visit does not require a referral. Patient was referred to us by Dr. Mathew Alexander."

Amount in Dispute: $95.92

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please note that in accordance with the Texas Labor Code §408.021(c), which reads: "Except in an emergency, all health care must be approved or recommended by the employee's treating doctor." The referral doctor indicated on the attached CMS Form 1500 is Matthew Alexander; however, the treating doctor on file with TDI is James Keith Rose and there is no record of a DWC-53 (Request for Change of Treating Doctor) to indicate otherwise. The treatment rendered on 05/27/10 was not at the recommendation of the treating doctor Keith Rose; therefore, no additional payment is recommended."

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
5/27/10	99213	N/A	95.92	0.00
			Total Due:	0.00

PART V: FINDINGS AND DECISION

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

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §133.203 sets out the medical fee guidelines for professional rendered on or after March 1, 2008.
3. Texas Labor Code §408.021 sets out the guidelines for entitlement to medical benefits.

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 6/9/2010

   - 165 – Payment denied/reduced for absence of, or exceeded referral
   - 5066 – Not treating doctor approved treatment

   Explanation of benefits dated 7/26/2010

   - 165 – Payment denied/reduced for absence of, or exceeded referral
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time.
   - 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
   - 5066 – Not treating doctor approved treatment
   - 5081 – Reduction or denial of payment resulting after a reconsideration was completed.

Issues

1. Was the service provided rendered by the treating doctor and does the documentation submitted indicate the treating provider referred the injured employee to the provider who rendered the service?
2. Is the requestor entitled to reimbursement?

Findings

1. The Requestor billed CPT code 99213 (an established office or outpatient office visit code) with documentation supporting that the rendering provider was Kristi Thulin, PA. Pursuant to Labor Code §408.021(c), Except in an emergency, all health care must be approved or recommended by the employee's treating doctor. Division records show that the treating doctor is James Keith Rose, MD. Therefore, the services that were rendered were not provided by the treating doctor in accordance with Labor Code §408.021. The documentation submitted in this dispute includes the bill with the referring provider documented as Matthew Alexander. Neither the medical record nor the bill supports that the treating doctor, James Keith Rose, MD referred or recommended that the injured worker seek treatment from Kristi Thulin, PA or any other provider. The requestor's position statement even states that the referring provider is Dr. Matthew Alexander. Therefore, the services that were rendered were not provided by the treating doctor in accordance with Labor Code §408.021.

Conclusion

For the reasons stated above, the division finds that the requestor has failed to establish that reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: 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 disputed services.

Authorized Signature	Medical Fee Dispute Resolution Officer	Date
	Susan Weber Grist, CPC	10/11/10

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (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. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

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