



## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### PART I: GENERAL INFORMATION

Requestor's Name and Address: Bexar County Healthcare 510 W. Davis St Dallas, TX 75208	MFDR Tracking #: M5-06-2004-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #:  LUMBERMENS MUTUAL CASUALTY CO BOX 42	Date of Injury:
	Employer Name:
	Insurance Carrier #:

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

Requestor's Position Summary: "The carrier failed to provide the request for reconsideration response EOB's for the outstanding dates of service of 7-12-06 and 07-14-06."

Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)
3. EOB(s)

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

Respondent's Position Summary: "Carrier maintains that it properly denied reimbursement for 10 additional sessions of a chronic pain management program... These sessions were not preauthorized and thus clearly not reasonable or necessary..."

Principle Documentation:

1. Response to DWC 60

### PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
7-28-05	F, 62, 850	97799-CP (\$100.00 x 8 units)	1, 5, 6	\$800.00
7-29-05, 8-11-05	62, 850	97799-CP (\$100.00 x 16 units)	2, 5, 6	\$1,600.00
8-10-05	50	97799-CP (\$100.00 x 8 units)	3, 5, 7	\$800.00
8-26-05	No EOB	97799 (\$100.00 x 8 units)	4	\$800.00
<b>Total Due:</b>				<b>\$4,000.00</b>

### PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

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

In an e-mail dated 5-30-07 the Requestor withdrew date of service 8-12-05. This will not be a part of this review.

1. These services were denied by the Respondent with reason code "F-Fee Guideline MAR Reduction," "62-Payment denied/reduced for absence of, or exceed, pre-certification/authorization. \$0.00," and "850-Services rendered appear to be un-authorized prior to treatment. \$0.00."
2. These services were denied by the Respondent with reason code "62-Payment denied/reduced for absence of, or exceed, pre-certification/authorization. \$0.00," and "850-Services rendered appear to be un-authorized prior to treatment. \$0.00."
3. These services were denied by the Respondent with reason code "50-These are non-covered services because this is not deemed a 'Medical Necessity' by the payer," "and," "889-This service was not considered reasonable or necessary for the medical causality problem."
4. Neither the Respondent nor the Requestor provided EOB's for these services. This review will be according to Rule 134.202. Per Rule 134.600 (h), the Requestor provided a copy of preauthorization letters dated 8-13-05 and 8-22-05 for (20) sessions of chronic pain management. This session is outside of the date range as listed on the preauthorization letter. However, it is part of the chronic pain management program. Reimbursement is recommended.
5. Per Rule 134.202(e)(5)reimbursement for non-CARF accredited Programs shall be 80% of \$125.00 per hour.
6. Per Rule 134.600 (h), the Requestor provided a copy of preauthorization letters dated 8-13-05 and 8-22-05 for (20) sessions of chronic pain management. These services were to be performed between 7-5-05 and 8-22-05. Reimbursement is recommended.
7. Per Rule 134.600 (h), the Requestor provided a copy of preauthorization letters dated 8-13-05 and 8-22-05 for 20 sessions of chronic pain management. These services were to be performed between 7-5-05 and 8-22-05. The Respondent denied these sessions for unnecessary medical treatment based on a peer review. Rule 133.301 (a) states "the Respondent 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 Legal and Compliance referral will be made for inappropriate denial of the preauthorized service per Rule 133.301(a).

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

Texas Labor Code Sec. §413.011(a-d)  
 28 Texas Administrative Code Sec. §133.301, §134.1, §134.202, §134.600

**PART VII: DIVISION DECISION AND/OR 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 reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of \$4,000.00 plus accrued interest, due within 30 days of receipt of this Order.

ORDER :

5-31-07

Authorized Signature

Medical Fee Dispute Resolution Officer

Date

**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.**