



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's Name and Address: Injury One Treatment Center 5445 La Sierra Dr., Suite 204 Dallas, Texas 75231-3444	MFDR Tracking #: M5-08-0028-01 Previous #: M4-06-0904-01
	DWC Claim #:
	Injured Employee:
	Date of Injury:
Respondent Name and Box #: AMERICAN HOME ASSURANCE CO BOX 19	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "The original EOB's were granted a recommended allowance, when resubmitted the carrier has not responded as of present... Preauthorization was granted through the utilization review department of Hallmark Insurance, medical necessity was established at that time."

Principal Documentation:

1. DWC 60 package
2. Total Amount Sought - \$29,875.00
3. CMS 1500s
4. EOBs
5. Preauthorization Letters

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "The provider has failed to provide any documentation to support the medical necessity of those ten additional service dates."

Principal Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
10-04-04 – 12-03-04	97799-CP-CA (\$125.00 x 8 hrs/day = \$1,000.00 x 29 days = \$29,000.00) (\$125.00 x 7 hrs/day = \$875.00 x 1 day = \$875.00)	45, 24, 18, and/or No EOB	1 - 6	\$29,875.00
Total Due:				\$29,875.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

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

1. These services were denied by the Respondent with reason code "45-Charges exceed your contracted/legislated fee arrangement," "24-Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan," "18-Duplicate claim/service," and/or no EOB's were received from either party.
2. Neither the Respondent nor the Requestor provided EOB's for some of these services. The Requestor submitted convincing evidence of carrier receipt for "Request for EOBs" in accordance with 133.307 (e)(2)(B). This review will be according to Rule 134.202.
3. These are not "duplicate bills." The disputed service was a bill submitted for reconsideration of payments. The Requestor has submitted these claims for reconsideration per Rule 133.304(k).
4. The Requestor stated in an e-mail on 11-27-07 that "There was no contract in 2004 with the carrier!" The Respondent failed to respond to several attempts to ascertain whether or not a contract existed. This dispute will be reviewed per Rule 134.202(e)
5. The Requestor provided a copy of preauthorization letters dated 9-29-04, 10-20-04 and 11-12-04 for 30 sessions of chronic pain management. 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."
6. Per Rule 134.202(e)(5)(E)(ii) the Chronic Pain Management Program shall be reimbursed at \$125.00 per hour for a CARF accredited program.

A Legal and Enforcement referral has been made for inappropriate denial of the preauthorized service per Rule 133.301.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section 413.031 and Section 413.0311
28 Texas Administrative Code Sections 133.307, 133.304, 134.1, 134.202
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of \$29,875.00 plus applicable accrued interest per Division Rule 134.803, due within 30 days of receipt of this Order.

DECISION:

ORDER:

Authorized Signature

Medical Fee Dispute Resolution
Director

12/17/07
Date

PART VIII: 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 148.3(c).

Under Texas Labor Code Section 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 Section 413.031.

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