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

SUMMIT REHABILITATION CENTERS
2420 EAST RANDOL MILL RD
ARLINGTON TX 76011-6335

Respondent Name
ST PAUL FIRE & MARINE INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 5

MFDR Tracking Number
M4-06-7263-01

MFDR Date Received
July 28, 2006

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim is compensable . . . The work conditioning program was preauthorized."

Amount in Dispute: $2,975.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not submit a response for consideration in this review.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
December 9, 2005 to March 23, 2006	Rehabilitation Services	$2,975.68	$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 §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.202 sets out the fee guideline for professional medical services.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on July 28, 2006. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on August 2, 2006 to send additional documentation relevant to the fee dispute as set forth in the rule.
5. On April 4, 2007, the requestor sent a revised table of disputed services indicating that certain previously disputed services were withdrawn and no longer in dispute. The requestor's revised table will be used as the basis for this review.

6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - UMO7 – 39 - SERVICES DENIED AT THE TIME AUTHORIZATION/PRE-CERTIFICATION WAS REQUESTED. BASED ON THE INFO AVAILABLE AT THE TIME OF REVIEW, THE PREAUTHORIZATION FOR THIS SERVICE APPEARS TO HAVE BEEN DENIED.
   - FEES – W1 – WORKERS COMPENSATION STATE F/S ADJ. REIMBURSEMENT BASED ON MAX ALLOWABLE FEE FOR THIS PROC. BASED ON MEDICAL F/S. OR IF ON IS NOT SPECIFIED, UCR FOR THIS ZIP CODE AREA.
   - NCWL – WORKER'S COMPENSATION CLAIM ADJUDICATED AS NON-COMPENSABLE. CARRIER NOT LIABLE FOR CLAIM OR SERVICE/TREATMENT. THE PROCEDURE/SERVICE IS NOT REIMBURSABLE BECAUSE COVERAGE IS NOT IN FORCE FOR THIS CLAIM.

Findings

1. Are there unresolved issues of compensability or liability with regard to disputed services?
2. Did the requestor submit copies of all explanations of benefits relevant to the fee dispute, or convincing evidence of carrier receipt of the provider request for an EOB, in accordance with the requirements of 28 Texas Administrative Code §133.307(e)(2)(B)?
3. Were the disputed services preauthorized?

Findings

1. The insurance carrier denied disputed date of service March 23, 2006 with reason code NCWL – "WORKER'S COMPENSATION CLAIM ADJUDICATED AS NON-COMPENSABLE. CARRIER NOT LIABLE FOR CLAIM OR SERVICE/TREATMENT. THE PROCEDURE/SERVICE IS NOT REIMBURSABLE BECAUSE COVERAGE IS NOT IN FORCE FOR THIS CLAIM." Former 28 Texas Administrative Code §133.305(a)(2), effective January 1, 2003, 27 *Texas Register* 12282, defines a medical fee dispute as a dispute over the amount of payment for health care rendered to an injured employee and determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 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. Review of the submitted documentation finds that there are unresolved issues of compensability, extent and/or liability for the same service(s) for which there is a medical fee dispute. No documentation was submitted to support that the issue(s) of compensability, extent and/or liability have been resolved prior to the filing of the request for medical fee dispute resolution; therefore these disputed services are not ripe for medical fee dispute resolution and will not be considered in this review.
2. Former 28 Texas Administrative Code §133.307(e)(2)(B), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include "a copy of each explanation of benefits (EOB) . . . relevant to the fee dispute or, if no EOB was received, convincing evidence of carrier receipt of the provider request for an EOB." Review of the submitted documentation finds that the request does not include copies of any EOBs for disputed date of service February 2, 2006. Neither has the requestor submitted convincing evidence of carrier receipt of the provider request for an EOB. The Division concludes that the requestor has not met the requirements of §133.307(e)(2)(B). Without documentation to support the insurance carrier's payment, or lack thereof, the Division cannot make a determination regarding the medical fee amounts for these disputed services. The requestor bears the burden of providing documentation to support that additional reimbursement is due. The requestor has failed to provide sufficient documentation to support that additional reimbursement is due for these disputed services; therefore, no additional reimbursement can be recommended.
3. The insurance carrier denied disputed date of service February 21, 2006 with reason code UMO7 – "39 - SERVICES DENIED AT THE TIME AUTHORIZATION/PRE-CERTIFICATION WAS REQUESTED. BASED ON THE INFO AVAILABLE AT THE TIME OF REVIEW, THE PREAUTHORIZATION FOR THIS SERVICE APPEARS TO HAVE BEEN DENIED." The requestor asserts that "The work conditioning program was preauthorized." In support of the requestor's assertion, the requestor submitted a utilization review letter indicating "Negotiated approval for four weeks of work conditioning . . . Dates request to be completed within: 1-19-06- through 2-19-06." The date of service in dispute is February 21, 2006. This date is outside the preauthorized date range approved in the submitted utilization review approval letter. No documentation was found to support that date of service February 21, 2006 was preauthorized. Former 28 Texas Administrative Code §134.600(b), effective March 14, 2004, 29 *Texas Register* 2349, states, in pertinent part, that "The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (h) or (i) of this section, only when the following situations occur: (A) an emergency, as defined in §133.1 of this title (relating to Definitions); (B) preauthorization of any health care listed in subsection (h) of this section was approved prior to providing the health care." Subsection (h)(9) states that non-emergency health care requiring preauthorization includes: "work hardening and work conditioning services provided in a facility that has not been approved for exemption by the commission." No documentation was submitted to support that the facility had been approved for exemption by the commission. No documentation was submitted to support an emergency. Preauthorization was required, but was not obtained prior to rendering the treatment for the disputed date of service; therefore, the Division concludes that the insurance carrier's denial code is supported. No reimbursement can be recommended.

Conclusion

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

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

Signature	[redacted] Medical Fee Dispute Resolution Officer	January 31, 2014 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.