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
HCH ANESTHESIOLOGY GROUP

Respondent Name
CONTINENTAL CASUALTY CO

MFDR Tracking Number
M4-09-0193-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
SEPTEMBER 28, 2004

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This procedure was preauthorized, per TWCC Rule '133.01(a)' "The insurance carrier shall not retrospectively review the medical necessity of a medical bill for treatments/services for which the HCP has obtained preauthorization under chapter 134 of this title'."

Requestor's Supplemental Position Summary Dated April 27, 2005: "I am writing you this letter to formally request that you go forward with the dispute as I have enclosed the PLN11, (TWCC21) on which the carrier states at the bottom of the page that due to a peer review performed on 4/27/04 the compensable injury has resolved as of 7/5/04 and any treatment after that is not reasonable or necessary and that the injury had resolved by 7/5/04. Well our date of service was 4/3/04 that is before the peer review and with in the date range that the carrier has agreed on the PLN11 that is covered and reasonable and necessary."

Requestor's Supplemental Position Summary Dated May 23, 2005: "our date of service was 4/3/04 that is before the peer review and with in the date range that the carrier has agreed on the PLN11 that is covered, compensable, reasonable and necessary. Therefore our services are not subject to these extent issues."

Requestor's Supplemental Position Summary Dated July 5, 2005: "This brings me to my first point and I have tried to resolve this with the carrier many times but they refuse to discuss this issue; our bill cannot possibly be subject to this dispute of extent as the carrier has clearly stated in there PLN11. Our service was preauthorized and is not subject to retrospective review. Our date of service is 04/03/2004 and this peer review was performed on 04/27/2004, which is 24 days after our date of service also. The PLN11 states they are disputing all dates of service after 07/05/2004 and nothing after that date is reasonable or necessary. Our bill is before that date. Our date of service is 04/03/2004 which is three months before their cut off date for treatment."

Amount in Dispute: $1,495.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier respectfully submits its TWCC-60 and MR 116 response with supporting documentation. The denial of the service is based on attached TWCC 21's as the effects of the compensable injury have resolved."

- TWCC21 dated December 6, 2002 – "Per Peer Review dated 11/11/02, the effects of the compensable injury have resolved. Based on this, it is the carrier's position that any current medical conditions alleged to be suffered by the claimant is not related to the compensable injury."

- TWCC21 dated July 13, 2004 – "Carrier disputes any additional treatment. Per Peer Review on 4-27-04 by Dr. Richard Silver, compensable injury of the lumbar strain DOI 1-15-99 has resolved. Current medical problems are not related to the above injury. Treatment and Medications after 7-5-04 (weaning period) are not reasonal [sic] and necessary. Clmt has the reight to request BRC."

Response Submitted by: Law Offices of Jeffrey M. Lust

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 2, 2004	CPT Code 00670-AA	$1,495.00	$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 §141.1 sets out the procedures for requesting and setting a Benefit Review Conference.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   Explanation of Benefits dated August 19, 2004
   - R-Extent of Injury.
   - 880-125-Denied per insurance: NC (Non-Covered) procedure or service. 100%
   - 920-002-In response to a provider inquiry, we have re-analyzed this bill and arrived at the same recommended allowance.
   - O-Denial after reconsideration.

Issues

1. Does a compensability, extent, and/or liability issue exist in this dispute?
2. Is the requestor eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for the disputed service based upon reason codes "R" and "880-125".

   According to 28 Texas Administrative Code §133.305(a)(2), "Medical Fee Disputes--Medical Fee Disputes involve 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 dispute is for reasons other than the medical necessity of the care (e.g. based upon the requirements of commission rules or fee guidelines). The dispute is resolved by the commission pursuant to commission rules, including §133.307 of this title (relating to Medical Dispute Resolution of a Medical Fee Dispute)."

   28 Texas Administrative Code §133.305(e)(2)(D) goes on to state that "if the carrier has raised a dispute pertaining to liability for the claim, compensability, or extent of injury, in accordance with §124.2 of this title (relating to Carrier Reporting and Notification Requirements), the request for an IRO will be held in abeyance until those disputes have been resolved by a final decision of the commission."

   28 Texas Administrative Code §133.307(e)(2)(D) states "if the carrier has raised a dispute pertaining to liability for the claim, compensability, or extent of injury, in accordance with §124.2 of this title (relating to Carrier Reporting and Notification Requirements), the request for an IRO will be held in abeyance until those disputes have been resolved by a final decision of the commission."

   A review of the submitted medical records finds that the disputed services were for anesthesia services that the respondent has disputed as not related to the compensable injury. The requestor did not submit any

documentation to support that the compensability/extent, and/or liability issue has been resolved; therefore, a compensability, extent, and/or liability issue exist in this dispute.

2. The requestor has failed to support that the disputed services rendered on April 2, 2004 is eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established 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 disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	11/13/2014 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.