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
PROFESSIONAL THERAPY SERVICES OF TEXAS

Respondent Name
EMPLOYERS ASSURANCE CO

MFDR Tracking Number
M4-09-7222-01

Carrier's Austin Representative
Box Number 04

MFDR Date Received
JANUARY 30, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated January 30, 2009: "Our request is prompted by the final denial explanation of benefits dated 11/12/2008 and received in our office 11/26/2008 which states the treatment was not medically necessary. Previous explanation of benefits indicate that extent of injury was not finally adjudicated. All procedures to provide treatment were followed with pre-certification being obtained twice from Uni-Med."

Requestor's Position Summary Dated March 28, 2009: "Per our telephone conversation, I am forwarding an updated table of unresolved claims and copies of the EOB's which reflect payments since the dispute was filed. Please advise of status or further action necessary on our part."

Amount in Dispute per Updated Table: $562.18

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The dates of service in question are: 2-11-08 / 4-15-08 / 4-21-08 / 4-23-08. I have once again reviewed the physical therapy notes submitted with the bills and again although the bill indicates they are billing for the correct ICD code the treatment provided is to a non-compensable body part which is the shoulder and back. The medical documentation does not support the billing code or compensable injury."

Response Submitted by: Employers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 11, 2008	CPT Code 97110	$32.13	$0.00
February 11, 2008	CPT Code 97140	$29.83	$0.00
February 11, 2008	CPT Code 97035	$12.24	$0.00
February 11, 2008	CPT Code G0283	$13.13	$0.00
April 15, 2008	CPT Code 97002	$48.50	$0.00
April 15, 2008	CPT Code 97110	$35.65	$0.00

April 15, 2008	CPT Code 97035	$14.69	$0.00
April 15, 2008	CPT Code 97033	$29.26	$0.00
April 21, 2008	CPT Code 97110	$71.30	$0.00
April 21, 2008	CPT Code 97035	$14.69	$0.00
April 21, 2008	CPT Code 97033	$29.26	$0.00
April 23, 2008	CPT Code 97110	$71.30	$0.00
April 23, 2008	CPT Code 97035	$14.69	$0.00
April 23, 2008	CPT Code 97033	$29.26	$0.00
April 30, 2008	CPT Code 97110	$71.30	$0.00
April 30, 2008	CPT Code 97035	$14.69	$0.00
April 30, 2008	CPT Code 97033	$29.26	$0.00
TOTAL		$562.18	$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 §134.202, titled *Medical Fee Guideline* effective for professional medical services provided on or after August 1, 2003, set out the reimbursement guidelines.
4. 28 Texas Administrative Code §141.1 sets out the procedures for requesting and setting a Benefit Review Conference.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W12-Extent of injury not finally adjudicated.
   - 16-Claim service lacks information which is needed for adjudication. Addl info is supplies using remittance advice remarks whenever appropriate. The diagnosis code codes not match up with the documentation provided.

Issues

1. Did the requestor file for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.305 and §133.307?
2. Is the requestor eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?

Findings

1. The requestor filed a dispute with the Medical Fee Dispute Resolution section at the Division on January 30, 2009.

   According to 28 Texas Administrative Code §133.305(a)(4), a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) goes on to state that "If a dispute regarding compensability, extent

of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." 28 Texas Administrative Code §133.307(e) (3) (H) requires that if the carrier has raised a dispute pertaining to compensability, extent of injury, or liability for the claim, the Division shall notify the parties of the review requirements pursuant to §124.2 of this title, and will dismiss the request until those disputes have been resolved by a final decision, inclusive of all appeals. 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. No documentation was submitted to support that the issue(s) of compensability, extent and/or liability have been resolved as of the undersigned date.

2. The requestor has failed to support that the disputed services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

For the reasons stated above, the requestor has failed to establish that the respondent's denial of payment reasons concerning liability for the injured employee's workers' compensation claim, compensability of that claim, and/or extent-of-injury issues with that claim have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 410 prior to the submission of a medical fee dispute request for the same services. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute. As a result, no amount is ordered.

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

		05/16/2014
Signature	Medical Fee Dispute Resolution Officer	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.