Texas Department of Insurance, Division of Workers' Compensation
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: Texas Health 5445 LaSierra Dr. #204 Dallas, TX 75231	MFDR Tracking #: M4-07-5769-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: Albertsons LLC Box 19	Date of Injury: Employer Name: Albertsons LLC Insurance Carrier #: YGU30457

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "The treatment rendered was preauthorized…I have tried to resolve the dispute by sending claims in for reconsideration…"

Principle Documentation:

1. DWC 60 package
2. CMS 1500s
3. EOBs
4. Preauthorization Approvals

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "Preauthorization was obtained for a chronic pain program to treat the CTS/RSD. Yet as part of a Benefit Dispute Agreement…the parties agreed that CTS and RSD were not part of the compensable injury."

Principle Documentation:

1. DWC 60 package
2. Benefit Dispute Agreement

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
5/8/06, 5-9-06, 5-11-06, 5/12/06	W9, 880-139	97799-CP-CA ($125.00 x 32 hours)	1, 4	$4,000.00
6/8/06-6/27/06	96, 880-118	97799-CP-CA ($125.00 x 52 hours)	2, 4	$7,500.00
5-10-06	No EOB	97799-CP-CA ($125.00 x 32 hours)	3, 4	$1,000.00
Total Due:				$12,500.00

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.

1. These services were denied by the Respondent with reason code "W9-Unnecessary medical treatment based on peer review," and "880-139-Reimbursment has been denied based upon the recommendation of a peer review 100%." Per Rule 134.600 (c)(1)(B) the Requestor provided a copy of preauthorization letters dated 5-5-06, 6-2-06 and 7-10-06 for 20 sessions of chronic pain management. The Respondent has reimbursed 7 of these sessions. The Respondent denied these sessions for unnecessary medical treatment based on a peer review. According to Rule 134.600 (c)(1)(B) "The carrier is liable for all reasonable and necessary medical costs relating to the health care that was approved prior to providing the health care." Recommend reimbursement per Rule 134.202(e)(5)(E).

2. These services were denied by the Respondent with reason code "96 (880-118) – Non-covered charges. Diagnosis codes listed are not for the allowed conditions in the claim. 100%." One of the diagnosis codes used by the Requestor on the CMS 1500 and the Request for Preauthorization was 923.2 – Contusion of wrist/hand. Therefore, treatment was to the compensable body part. Recommend reimbursement per Rule 134.202(e)(5)(E).

3. Neither the Respondent nor the Requestor provided EOB's for 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(e)(5)(E).

4. Per Rule 134.202(e)(5)(E) the Chronic Pain Management Program shall be reimbursed at $125.00 per hour for a CARF accredited program.

A Legal and Compliance referral has been made for inappropriate denial of the preauthorized services on 5-8-06, 5-9-06, 5-11-06 and 5/12/06 per Rule (133.307(e)(3)(B).

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §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 $12,500.00 plus accrued interest, due within 30 days of receipt of this Order.

ORDER :

	Donna Auby Medical Fee Dispute Resolution Officer	7-9-07
	Amy Rich	7-9-07
Authorized Signature	Director, Medical Fee Dispute Resolution	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.