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
DIPTI PATEL DC

Respondent Name
AMERICAN HOME ASSURANCE

MFDR Tracking Number
M4-08-6495-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 2, 2008

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "These medical services do NOT require pre-authorization when performed within the first two weeks of the date of injury."

Amount in Dispute: $316.19

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier would not that healthcare delivered after May 1, 2007 is controlled by the Official Disability Guidelines (ODG). Rule 137.100 provides that any treatment in excess of the ODG or listed in Rule 134.600 requires pre-authorization. Carrier has denied the treatment in question as exceeding the ODG and requiring pre-authorization. Justification offered by the provider is dated and irrelevant. Further, even without pre-authorization, the care is not medically necessary to treat the compensable injury as set out in the ODG. Carrier maintains its position."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 4, 2008 through February 11, 2008	97140, 97032-GP, 97035, 97110, 97112	$316.19	$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 §134.600 sets out the guidelines for Preauthorization, Concurrent Review, and Voluntary Certification of Health Care.
3. 28 Texas Administrative Code §137.100 sets out the treatment guidelines.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - BL – To avoid duplicate bill denial for all recon/adjustments/additional pymnt requests. Submit a copy of this EOR or clear notation.
   - 39 – Services denied at the time authorization/pre-certification was requested.
   - W1 – Workers compensation state fee schedule adjustment.

Issues

1. Was preauthorization required for physical therapy services?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.600 "(p) Non-emergency health care requiring preauthorization includes ... (12) treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier."

   28 Texas Administrative Code §137.100 "(a) Health care providers shall provide treatment in accordance with the current edition of the *Official Disability Guidelines - Treatment in Workers' Comp,* excluding the return to work pathways, (ODG), published by Work Loss Data Institute (Division treatment guidelines), unless the treatment(s) or service(s) require(s) preauthorization in accordance with §134.600 of this title (relating to Preauthorization, Concurrent Review and Voluntary Certification of Health Care) or §137.300 of this title (relating to Required Treatment Planning."

   The disputed charges therefore required preauthorization. The requestor submitted insufficient documentation to support that preauthorization was obtained for the physical therapy services rendered on February 4, 2008 through February 11, 2008. As a result, reimbursement cannot be recommended.
2. Review of the submitted documentation finds that the requestor is not entitled to reimbursement for CPT codes 97140, 97032-GP, 97035, 97110 and 97112.

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

		April 1, 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.