Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

CORRIDOR MEDICAL CLINIC
1348 HWY 123 SOUTH STE A
SAN MARCOS TX 78666

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

Carrier's Austin Representative Box
Box Number 45

MFDR Tracking Number
M4-10-1851-01

MFDR Date Received
November 20, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Despite receiving authorization for treatment and no notice of denial The State office of Risk Management is still denying payment for the Dates of Service above…according to authorization number1022966 F 0, the compensable injury was for the left knee. Approval for services 'outpatient physical therapy three times per week for four weeks to the left knee consisting of therapeutic exercises with no more than four units per session' was received on 4/10/2009…Pre-Authorization was received;…Lastly, according to denial code 50, the 'service [was] not deemed 'medically necessary' by payer' and payment was denied. However, in the preauthorization it is stated that the 'post operative therapy, and the frequency, duration, modalities, and proposed units is appropriate under ODG criteria. It is stated that 'the preceding authorization is based only on medical necessity'. Therefore, approval for the services rendered was medically necessary, and warrants reimbursement."

Amount in Dispute: $1565.94

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Office filed a PLN-11 on 12/23/08 disputing entitlement of disability benefits and Medical Treatment unrelated to the Left Knee Strain/Sprain. It goes on to state that the Carrier accepts the compensable injury is limited to a Left Knee Strain/Sprain ONLY…Further review of dates of service 4/6/09 and 4/8/09 and found that services were performed without the requestor obtaining preauthorization prior to starting treatment, therefore the Office will maintain its denial for W12…and 197….Although preauthorization was obtained for the services performed from date of service 4/15/09 to 5/29/09, the Office determined through an in-depth review of the claim that the injured worker had surgery performed that was not authorized…"

Response Submitted by: SORM; PO BOX 13777; AUSTIN TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 3 2009 to May 29, 2009	97001, 97110, 97032	$1565.94	$1280.52

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 a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated May 4, 12, 28, 2009 and June 5, 2009
   - W12 – Extent of injury. Not finally adjudicated

   Explanation of benefits dated May 22, 27, 2009; June 24, 2009 and August 4, 2009
   - 50 - service not deemed medically necessary by payer
   - T13 – medical necessity denial. Appeal within 11 months of DOS.
   - Additional note: Treatment is not related to the work comp injury. Surgery was not approved; therefore this post op treatment is not R/N.

   Explanation of benefits dated May 11, 2009
   - 191 – Claim denied, not work related
   - W1 – Workers' Compensation State Fee Schedule Adj

   Explanation of benefits dated May 4, 2009 and June 5, 2009
   - 197 – payment adjusted for absence of precert/preauth
   - W1 - Workers' Compensation State Fee Schedule Adj

   Explanation of benefits dated October 30, 2009
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time.

Issues

1. Did the respondent support its denial of not work related and extent of injury?
2. Did the respondent support its denial of not medically necessary and no preauthorization?
3. Did the respondent support its denial reason of no preauthorization for date of service April 8, 2009?
4. Is the requestor entitled to reimbursement?

Findings

1. The respondent denied reimbursement for the disputed services based upon reason code "191 – claim denied, not work related" and "W12 – Extent of injury. Not finally adjudicated."

   According to the December 23, 2008 PLN-11, "The Carrier accepts the compensable injury is limited to a left knee strain/sprain only." The medical billing including the billing diagnosis codes are reviewed. Because all the treatment rendered on the disputed dates of service are for the compensable injury, the Division concludes that there are no unresolved issues of extent. Therefore, this dispute will be reviewed per Division rules and fee guidelines.
2. The respondent denied reimbursement for disputed dates of service May 1, 13, and 29, 2009 based upon reason code "50 – service not deemed medically necessary by payer" and "T13 – medical necessity denial…" The respondent also denied reimbursement based upon "197 – payment adjusted for absence of precert/preauth" for disputed date of service May 27, 2009.

   On April 10, 2009, the requestor received preauthorization approval #1022966 F O for "outpatient physical therapy three times a week for four weeks to the left knee for therapeutic exercise with no more than 4 units per session…This post operative therapy, and the frequency, duration, modalities and proposed units is appropriate under ODG criteria".

   Texas Labor Code 413.014(e) states "If a specified health care treatment or service is preauthorized as provided in this section, that treatment or service is not subject to retrospective review of the medical necessity of the treatment or service." Therefore, the respondent's denial reasons of "50", "T13", and "197" are not supported.

   Neither party submitted an explanation of benefits for date of service April 6, 2009 for CPT codes 97110 and 97032 which require preauthorization per 28 Texas Administrative Code §134.600. A review of the preauthorization approval does not cover this date of service. No reimbursement can be recommended.
3. Physical therapy rendered on April 8, 2009 was denied for no preauthorization. A review of the preauthorization approval does not cover this date of service. The respondent's denial reason is supported.

No reimbursement can be recommended.

Requestor has supported position that the disputed physical therapy sessions from April 15, 2009 to May 29, 2009 were preauthorized per 28 Texas Administrative Code §134.600; therefore, the requestor is entitled to reimbursement as follows per 28 Texas Administrative Code §134.203:

- Code 97001: WC CF 53.68 ÷ Medicare CF 36.0666 x participating amt $67.08 = $99.84; requestor seeks $99.82, this amount is recommended.
- Code 97032: WC CF 53.68 ÷ Medicare CF 36.0666 x participating amt $15.42 = $22.95; requestor seeks $22.94, this amount is recommended.
- Code 97110: WC CF 53.68 ÷ Medicare CF 36.0666 x participating amt $26.83 x 2 units = $79.87, requestor seeks $79.85, this amount recommended
- Code 97110: WC CF 53.68 ÷ Medicare CF 36.0666 x participating amt $26.83 x 3 units = $119.80, requestor seeks $119.77, this amount recommended
- Code 97110: WC CF 53.68 ÷ Medicare CF 36.0666 x participating amt $26.83 x 4 units = $159.73, requestor seeks $159.69 x six days = $958.14, this amount recommended

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports reimbursement sought by the requestor. For the reasons stated above, the Division finds that the requestor has established that reimbursement is due for all dates of service in this dispute except April 6 and 8, 2009. As a result, the amount ordered is $1280.52.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1280.52 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		JUNE 13, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN 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.