



# 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](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

NOVA HEALTHCARE

**Respondent Name**

LM INSURANCE CORP

**MFDR Tracking Number**

M4-10-4852-01

**Carrier's Austin Representative**

Box Number 01

**MFDR Date Received**

JULY 27, 2010

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "no authorization"

**Amount in Dispute:** \$266.94

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The provider is seeking reimbursement for procedure code 97535, 97112 and 97530. A copy of the provider's PT/OT Pre-Authorization Request Form is enclosed. Please note that they did **NOT** require pre-authorization for procedure code 97535 so the charges are denied accordingly. Also enclosed is a copy of the approval/denial letter from our Utilization Review department which was mailed to the provider on October 7, 2009. Pre-authorization was granted for procedure code **97110 only**. **The ODG guidelines do recommend PT including exercise, but do not have a recommendation for neuromuscular re-education or therapeutic activities therefore the charges for 97112 and 97530 are denied accordingly also.**"

**Response Submitted by:** Liberty Mutual Insurance Co.

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 9, 2009 October 14, 2009	CPT Codes 97535, 97112, and 97530	\$266.94	\$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, requires preauthorization for specific treatments and services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 39-Services denied at the time authorization/ore-certification was requested.
  - X388-Pre-authorization was requested but denied for this service per DWC Rule 134.400.
  - X170-Pre-authorization was required, but not requested for this service per DWC Rule 134.600.

**Issues**

1. Did the requestor obtain preauthorization approval for the disputed physical therapy services?

**Findings**

Per 28 Texas Administrative Code §134.600(p)(5)(A) the non-emergency healthcare that requires preauthorization includes: “(5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (A) Level I code range for Physical Medicine and Rehabilitation, but limited to:

- (i) Modalities, both supervised and constant attendance;
- (ii) Therapeutic procedures, excluding work hardening and work conditioning.”

On October 7, 2009, the requestor obtained preauthorization approval for six (6) sessions of physical therapy sessions code 97110. No documentation was submitted to support preauthorization was obtained for the disputed services. As a result, reimbursement is not recommended.

**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	04/17/2014 Date
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***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.**