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
HAROLD W. GUNN

Respondent Name
NEW HAMPSHIRE INSURANCE COMPANY

MFDR Tracking Number
M4-11-0695-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 20, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Not told that pre-auth was required in TX we're in UT."

Amount in Dispute: $850.08

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not submit a response for consideration in this dispute.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 21, 2010 to April 7, 2010	Procedure Codes 97012 and 97014	$850.08	$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 rules regarding preauthorization of health care.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 19 – 197 - PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.

Issues

1. Under what authority is the request for medical fee dispute resolution considered?
2. Has the requestor met the requirements of 28 Texas Administrative Code §133.307?
3. Did the disputed services require preauthorization?
4. Is the requestor entitled to reimbursement?

Findings

1. The requestor is a health care provider that rendered disputed services in the state of Utah to an injured employee with an existing Texas Workers' Compensation claim. The health care provider was dissatisfied with the insurance carrier's final action. The health care provider requested reconsideration from the insurance carrier and was denied payment after reconsideration. The health care provider has requested medical fee dispute resolution under 28 Texas Administrative Code §133.307. Because the requestor has sought the administrative remedy outlined in 28 Texas Administrative Code §133.307 for resolution of the matter of the request for additional payment, the Division concludes that it has jurisdiction to decide the issues in this dispute pursuant to the Texas Workers' Compensation Act and applicable rules.

2. Former 28 Texas Administrative Code §133.307(c)(2)(A), effective May 25, 2008, 33 *Texas Register* 3954, requires that the request shall include "a copy of all medical bill(s) . . . as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration." Review of the submitted documentation finds that the requestor has not provided a copy of the medical bill(s) as originally submitted to the carrier or as submitted for reconsideration. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(A).

   Former 28 Texas Administrative Code §133.307(c)(2)(E), effective May 25, 2008, 33 *Texas Register* 3954, requires that the request shall include "a copy of all applicable medical records specific to the dates of service in dispute." Review of the submitted documentation finds that the requestor has not provided copies of all medical records specific to the dates of service in dispute. The requestor did not submit documentation to support the services as billed. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(E).

3. Former 28 Texas Administrative Code §134.600(c), effective May 2, 2006, 31 *Texas Register* 3566, provides that:

   > The carrier is liable for all reasonable and necessary medical costs relating to the health care:
   > (1) listed in subsection (p) or (q) of this section only when the following situations occur:
   > (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions);
   > (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care;

   28 Texas Administrative Code §134.600(p)(5) states that the non-emergency health care requiring preauthorization includes:

   > 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;

   Review of the requestor's *Table of Disputed Services* finds that the procedure codes in dispute are 97012 and 97014. These codes represent services listed in the Healthcare Common Procedure Coding System (HCPCS) Level I code range for Physical Medicine and Rehabilitation as supervised modalities. No documentation was found to support an emergency. Accordingly, the Division concludes that the disputed services required preauthorization.

4. The insurance carrier denied disputed services with reason code 19 – "197 - PRECERTIFICATION/ AUTHORIZATION/NOTIFICATION ABSENT." Review of the submitted information finds no documentation to support preauthorization of the disputed services. The insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has failed to establish 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 services in dispute.

Authorized Signature

	Grayson Richardson	February 27, 2015
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.