



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

ALLIED MEDICAL CENTERS

Respondent Name

NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number

M4-11-4775-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

AUGUST 15, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Upon further review we are noting that the dates of service fall within ten weeks of the initial date of injury, therefore do not require a preauthorization for services rendered."

Amount in Dispute: \$560.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following six physical therapy dates have been paid: 2-15-2011, 2-21-2011, 2-15-2011, 3-7-2011 and 3-14-2011. Services for the dates of 3-16-2011 and 3-21-2011 were not preauthorized nor do they fall within the initial six visit timeframe."

Response Submitted By: Pappas & Suchma, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 16, 2011 March 21, 2011	CPT Code 97110-GP (x3 units)	\$168.00/each	\$0.00
March 16, 2011 March 21, 2011	CPT Code 97112-GP	\$56.00/each	\$0.00
March 16, 2011 March 21, 2011	CPT Code 97140-GP	\$56.00/each	\$0.00
TOTAL		\$560.00	\$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

- 28 Texas Administrative Code §133.307, effective May 25, 2008 sets out the procedures for resolving a medical fee dispute.
- 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:
- 19-(197) Precertification/authorization/notification absent.

Issues

Does a preauthorization issue exist? Is the requestor entitled to reimbursement?

Findings

According to the explanation of benefits, the respondent denied reimbursement for the disputed services based upon a lack of preauthorization.

28 Texas Administrative Code §134.600(p)(5), requires preauthorization for “ 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;
- (iii) Orthotics/Prosthetics Management;
- (iv) Other procedures, limited to the unlisted physical medicine and rehabilitation procedure code; and

(B) Level II temporary code(s) for physical and occupational therapy services provided in a home setting;

(C) except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following:

- (i) the date of injury, or
- (ii) a surgical intervention previously preauthorized by the carrier.”

The respondent states that payment was issued for the initial six visits of physical therapy from February 15, 2011 through March 14, 2011. Per 28 Texas Administrative Code §134.600(p)(5)(C), preauthorization was required for the disputed services rendered March 16, 2011 and March 21, 2011. The requestor did not submit any documentation to support preauthorization was obtained. 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

	Elizabeth Pickle, RHIA	5/5/2014
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.