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 and Address

DR. DAVID R KAISER
16111 SAN PEDRO NO 109
SAN ANTONIO TX 78232

Respondent Name

Via Metropolitan Transit

Carrier's Austin Representative

Box Number 16

MFDR Tracking Number

M4-12-1527-01

MFDR Date Received

January 9, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "97032 was authorized and performed in time allowed"

Amount in Dispute: $117.54

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Acknowledgement of medical fee dispute received however, no written response submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 8 – 23, 2011	Physical Therapy	$117.54	$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 §134.203 sets out the fee guideline procedures for professional medical services.
3. 28 Texas Administrative Code §133.250 sets out procedures for reconsideration for payment of medical bills.
4. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1A – Workers Compensation State Fee Schedule Adjustment
   - 58J – Processed based on multiple or concurrent procedure rules
   - 97A – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 198C – Precertification/authorization exceeded*Treatment/service was not part of treatment plan.*
   - 151C – Payment adjusted because the payer deems the information submitted does not support this

many/frequency of services.
- 193A – Original payment decision is being maintained.

Issues

1. Were the services authorized?
2. Was the reconsideration request in compliance with applicable rule?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied claim originally as 193C – "Precertification/authorization exceeded *Treatment/service was not part of treatment plan.*" Review of submitted medical claim shows claim line correction to 97032 however, claim submitted to carrier contained G0283. Procedure code G0283 was not included in pre-authorization therefore; the carriers' denial is supported.

2. 28 Texas Labor Code §133.250(d) states, "the request for reconsideration shall: (1) reference the original bill and include the same billing codes, date(s) of service, and dollar amounts as the original bill;" Review of the submitted medical claims shows handwritten code "97032" and note stating, "REQUEST FOR RECON Process 97032 per Auth# AP175861 90 mins of P.T. approved." Review of the Explanation of benefits for each dates of service August 8 – 23, shows G0283 as submitted code on claim line. The carriers' denial is supported as the request for reconsideration contained a hand-written code that was not on the original bill. The division concludes provision of 28 TAC §133.250(d) (1) were not met.

3. The submitted medical bill originally contained an un-authorized claim line and the reconsideration request was done with a different procedure code. Additional payment cannot be 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	January 21, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request 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 §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.