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
Jamie L Rios

Respondent Name
State Office of Risk Management

MFDR Tracking Number
M4-13-3306-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
August 15, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…Since, treatment was provided within 2 weeks of the DOI, this is a false denial because we did not exceed the DWC guidelines."

Amount in Dispute: $45.89

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Although the services are within the initial 14 days from date of injury, there was preauthorization obtained to include this date of service which did not include Ultrasound therapy and Electrical Stimulation."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 29, 2012	97035, 97032	$45.89	$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 the procedures for Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 198 – Payment denied/reduced for exceeded precertification/authorization
   - 193 – Original payment decision is being maintained

Issues

1. Did the requestor support services did not require authorization?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor was seeking exception under DWC rule 134.600(p)(5)(C) as "…first six visits of physical or occupation therapy following the evaluation when such treatment is rendered within the first two weeks immediately following: the date of injury." 28 Texas Labor Code §134.600(p) (12) states in pertinent part, "treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier." Review of the ODG guidelines finds the disputed services, AMA CPT code, (97035) - Application of a modality to 1 or more areas; ultrasound, each 15 minutes and (97032) - Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes, were not supported by treatment guidelines (exceeded the adopted treatment guidelines) and were not authorized by Forte as found by Notice of Utilization Review Findings dated October 30, 2012. The carrier's denial is supported as no exception to Rule 134.600(p)(5) was found.
2. Provisions of applicable Division rules not met. Therefore, no payment can 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

		June , 2014
Signature	Medical Fee Dispute Resolution Officer	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.