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
University General Hospital

Respondent Name
Houston ISD

MFDR Tracking Number
M4-14-0486-01

Carrier's Austin Representative
Box Number 21

MFDR Date Received
October 10, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Based on the Pre-authorization sheet she clearly wrote 1 PT evaluation and 1 PT treatment."

Amount in Dispute: $2,021.24

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Provider has not provided any documentation of proof of authorization for Physical Therapy services given from the carrier and no required Pre Authorization is on file thru the Utilization Review Agent; therefore we are continuing to stand on our denial as such."

Response Submitted by: Injury Management Organization, Inc., 10235 West Little York Road, Suite 265, Houston, TX 77040

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 15, 2012	Physical Therapy	$2,021.24	$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 guidelines for prospective and concurrent review of health care.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 16 – Claim/service lacks information which is needed for adjudication
   - 197 – Precertification/authorization absent
   - 193 – Original payment decision is being maintained

Issues

1. Did the requestor support services received prior authorization?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Labor Code §134.600(p)(5) states in pertinent part, "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;
   (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;

   Review of the submitted documentation finds;

   a. Pre-authorization request from University General Hospital

   Nothing to support the carrier gave authorization was found.
2. The requestor did not support a prior authorization was received therefore, no reimbursement is 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	April 15, 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.