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
ERIC A VANDERWERFF DC

Respondent Name
LIBERTY INSURANCE CORP

MFDR Tracking Number
M4-14-2558-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
APRIL 17, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The services rendered for the dates listed above are, in fact, pre-authorized services. The carrier, Liberty Mutual, APPROVED post-operative physical therapy for 10 visits, ref # 131490113S001001 (see attached approval letter). The 10 visits of pre-authorized services were rendered on 5/31/13…and 6/27/13."

Requestor's Position Summary dated May 28, 2014: "Payment on 06/19/13 was just received last week and was paid in full."

Amount in Dispute: $364.01

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Preauthorization was given for '10 initial post-operative physical therapy visits' to begin on 5/30/13 and 10 total visits have been paid…For services on 6/19/13 there was an error in the units entered into our system. The units have been corrected and additional payment is being processed in the amount of $134.47 for code 971110. The EOB has not yet finalized but will be provided once it becomes available. Services of 6/27/13 remain denied. No preauthorization was requested for an 11th date of service."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 27, 2013	CPT Code 97140-59	$42.50	$0.00
June 27, 2013	CPT Code 97110-GP (X4)	$187.04	$0.00
TOTAL		$364.01	$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, effective July 1, 2012, requires preauthorization for physical therapy services.
3. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197-No code description provided and not listed on 837 code set for ANSI claim adjustment reason code.
   - X170-Pre-authorization was required, but not requested for this service per DWC rule 134.600.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

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

Findings

28 Texas Administrative Code §134.600(p)(5) requires preauthorization for physical and occupational therapy services.

On June 3, 2013, the requestor obtained preauthorization approval for "10 sessions of therapy consisting of joint mobilization, myofascial therapy, and rehabilitative exercises, not to exceed 4 units per treatment encounter." The preauthorization report lists the date commencing on "05/30/2013."

The respondent contends that reimbursement is not due because "The 10 visits which were preauthorized and have been paid are: 5/30/13, 5/31/13, 6/5/13, 6/6/13, 6/10/13, 6/17/13, 6/19/13, 6/20/13, 6/24/13, and 6/26/13."

The Division finds that the respondent supported position that the disputed date of service is outside of the ten preauthorized sessions. 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

Signature	Medical Fee Dispute Resolution Officer	05/30/2014 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.