



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

Helping Hands Chiropractic

Respondent Name

East TX Educational Ins Assn

MFDR Tracking Number

M4-14-3682-01

Carrier's Austin Representative

Box Number 17

MFDR Date Received

August 18, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The first issue begins with the lack of authorization after the fourth visit. I called in to the insurance company East Texas Education o 5/9/2014 and spoke to Kelly, the adjustor for this case, and I was informed by her and also confirmed with another person within the company that the authorization is not required until after 7th visit."

Amount in Dispute: \$996.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Per Texas Administrative Code, Rule 134.600 (p) (5) (C) (i), (ii), preauthorization is not required for the first 6 sessions of physical therapy rendered within 2 weeks after the date of injury of date of approved surgery. The dates of service in question are all after the first 2 weeks of the date of injury and we have no record of claimant having had surgery. As such, preauthorization would be required."

Response Submitted by: CAS-Claims Administrative Services, Inc

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 23, 2014 through June 30, 2014	Physical Therapy	\$996.00	\$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 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 721 – Per rule 134.600 of the Texas Administrative Code, this procedure requires preauthorization. Preauthorization not obtained
 - 197 – Payment denied/reduced for absence of precertification/authorization

Issues

- 1. Did the requestor support authorization was not required?
- 2. Is the requestor entitled to reimbursement?

Findings

- 1. The carrier denied the disputed services as 197 – “Payment denied/reduced for absence of precertification/authorization.” 28 Texas Labor Code §134.600 (p) states in pertinent part, “Non-emergency health care requiring preauthorization includes: (5) 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;(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 insurance carrier;

Review of the submitted documentation finds the date range from the date of injury until the first date of service is greater than two weeks. The carrier’s denial is supported.

- 2. The requirements of Rule 134.600 were not met. No additional 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

Signature	Medical Fee Dispute Resolution Officer	January , 2015 Date
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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.