TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MALONEY CHIROPRACTIC CLINIC

MFDR Tracking Number
M4-16-0650-01

MFDR Date Received
November 10, 2015

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

Carrier's Austin Representative
Box Number 54

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I spoke to Texas Mutual Insurance they said that although there is a referral from a physician for treatment in our office, there was and is still need for prior authorization from their insurance company. I told them I was unaware of that since in Arizona if you have a referral form a physician for care that is automatically the authorization for case as well accepted by AZ Worker's Compensation carriers... Now I am appealing to you, at the Medical Fee Dispute Resolution, to fairly consider overturning Texas Mutual Insurance's denial decision for medically necessary care rendered to [injured employee] for a work related injury sustained on [date of injury.]"

Amount in Dispute: $2,860.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requester billed physical therapy these dates without preauthorization as required by Rule 134.600 (p) (5) (C). For this reason Texas Mutual declined to issue payment. The requestor billed for manipulations performed on the knee. ODG does not recommend manipulations to the knee and thus preauthorization is required."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 25, 2014 through December 16, 2014	98943, 97140 and 97110	$2,860.00	$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

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 Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care.
3. 28 Texas Administrative Code §137.100 sets out the Treatment Guidelines and applies to health care provided on or after May 1, 2007.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - CAC-197 – Precertification/authorization/notification absent.
   - 762 – Denied in accordance with 134.600(p) (12) treatment/service in excess of DWC treatment guidelines (ODG). Per disability management rules.
   - 930 – Pre-authorization required, reimbursement denied.
   - CAC-W3 – IN accordance with TDI-DWC 134.804, this bill has been identified as a request for reconsideration or appeal.
   - CAC-193 – Original payment decision is being maintained.
   - 350 – In accordance with TDI-DWC Rule 134.804. This bill has been identified as a request for reconsideration or appeal.
   - 891 – No additional payment after reconsideration.

Issues

1. Did the requestor seek resolution through Texas Workers' Compensation?
2. Did the requestor obtain preauthorization for CPT Codes 97140 and 97110?
3. Does CPT Code 98943 require preauthorization per 28 Texas Administrative Code §137.100?
4. Is the requestor entitled to reimbursement?

Findings

1. The requestor provided services in the state of Arizona on November 25, 2014 through December 16, 2014 to an injured employee with an existing Texas Workers' Compensation claim. The requestor was dissatisfied with the insurance carrier's final action. The requestor filed for reconsideration and was denied payment after reconsideration. The requestor filed for dispute resolution under 28 Texas Administrative Code §133.307. The Division concludes that because the requestor sought the administrative remedy outlined in 28 Texas Administrative Code §133.307 for resolution of the matter of the request for additional payment, the dispute is to be decided under the jurisdiction of the Texas Workers' Compensation Act and applicable rules.

2. The requestor seeks reimbursement for CPT Codes 97140 and 97110 rendered on November 25, 2014 through December 16, 2014. The insurance carrier denied the disputed services with denial reduction codes "CAC-197 – Precertification/authorization/notification absent," and "930 – Pre-authorization required, reimbursement denied."

   Per 28 Texas Administrative Code §134.600 states in pertinent part, "(p) 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."

   The Division finds that the requestor submitted insufficient documentation to support that preauthorization was obtained for the disputed services rendered on November 25, 2014 through December 16, 2014, as required by 28 Texas Administrative Code §134.600. As a result, reimbursement cannot be recommended for CPT Codes 97140 and 97110 rendered on November 25, 2014 through December 16, 2014.

3. The requestor seeks reimbursement for CPT Code 98943 rendered on November 25, 2014 through December 16, 2014. The insurance carrier denied the disputed services with denial reduction codes "CAC-197 – Precertification/authorization/notification absent," "930 – Pre-authorization required, reimbursement denied," and "762 – Denied in accordance with 134.600(p) (12) treatment/service in excess of DWC treatment guidelines (ODG). Per disability management rules."

   Per 28 Texas Administrative Code §134.600 states in pertinent part, "(p) Non-emergency health care requiring preauthorization includes... (12) 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. This requirement does not apply to drugs prescribed for claims under §§134.506, 134.530 or 134.540 of this title (relating to Pharmaceutical Benefits)."

   Per 28 Texas Administrative Code §137.100 "(c) Health care provided in accordance with the Division treatment guidelines is presumed reasonable as specified in Labor Code §413.017, and is also presumed to be health care reasonably required as defined by Labor Code §401.011(22-a)."

Per 28 Texas Administrative Code §137.100, "(d) The insurance carrier is not liable for the costs of treatments or services provided in excess of the Division treatment guidelines unless: (1) the treatment(s) or service(s) were provided in a medical emergency; or (2) the treatment(s) or service(s) were preauthorized in accordance with §134.600 or §137.300 of this title."

Per 28 Texas Administrative Code §137.100 states, "(f) A health care provider that proposes treatments and services which exceed, or are not included, in the treatment guidelines may be required to obtain preauthorization in accordance with §134.600 of this title, or may be required to submit a treatment plan in accordance with §137.300 of this title."

Review of the ODG identifies manipulations as not recommended; as a result, CPT Code 98943 is subject to preauthorization. The Division finds that the requestor submitted insufficient documentation to support that preauthorization was obtained for the disputed CPT Code 98943 rendered on November 25, 2014 through December 16, 2014, as required by 28 Texas Administrative Code §137.100. As a result, reimbursement cannot be recommended for CPT Codes 98943 rendered on November 25, 2014 through December 16, 2014

4. Review of the submitted documentation finds that the disputed services were subject to preauthorization. The requestor submitted insufficient documentation to support that preauthorization was obtained. As a result, the requestor is not entitled to reimbursement for the disputed services rendered on November 25, 2014 through December 16, 2014.

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

		December 10, 2015
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.