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
Select Physical Therapy

Respondent Name
Advantage Workers Compensation

MFDR Tracking Number
M4-18-2579-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
March 14, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We feel, based on the documentation provided and the fact that we had requested authorization, that we should be reimbursed for the services provided."

Amount in Dispute: $2,703.55

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider should have filed the request for preauthorization with the correct URA or with Gallagher Bassett. Not having done so, it follows that the provider never received approval for its request for preauthorization. The carrier has denied the bill on the basis of lack of preauthorization. The provider is not entitled to reimbursement because those services required preauthorization."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 28, 2017 through May 16, 2017	Physical Therapy Services	$2,703.55	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 requirements for prior authorization.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 24G12 – Precertification authorization or notification is absent
   - 219 – Based on extent of injury

Issues

1. Are the insurance carrier's reasons for denial of payment supported?

Findings

1. The requestor is seeking reimbursement of physical therapy services rendered from March 28, 2017 through May 16, 2017. The insurance carrier denied disputed services with claim adjustment reason code 219 – "Based on extent of injury" and 24G12 – "Precertification authorization or notification is absent."

   Review of the "Benefit Dispute Agreement" dated February 18, 2018 finds the "extent of injury" denial was not maintained. The other denial for lack of prior authorization is discussed below.

   28 Texas Administrative Code §134.600 (p) (5) 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;
   >
   > (iii) Orthotics/Prosthetics Management;
   >
   > (iv) Other procedures, limited to the unlisted physical medicine and rehabilitation procedure code;

Review of the submitted information finds that a request for 12 visits of physical therapy was made on April 4, 2017. This request was sent to fax number 615-778-5135, phone number 800-488-4929 addressed to Pre Cert Department. Review of the "Claim Administration Contact Information" at https://txcomp.tdi.state.tx.us/TXCOMPWeb/common/home.jsp, for the injured worker found preauthorization should have gone to "Gallagher Bassett Services Inc" at a phone number of 1-800-880-6201.

The carrier states, "…the provider never received approval for its request for preauthorization." Based on our review, the Division finds the carrier's response is supported as insufficient evidence was found to support the health care provider requested and received prior authorization before the disputed services were provided. Therefore, no payment 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 on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 11, 2018 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §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 MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **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.