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
Doctors Hospital at Renaissance

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-19-0138-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
September 12, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Due to no knowledge of claim case open with insurance carrier we fail to obtained authorization for the service provided and for the out of network approval."

Amount in Dispute: $3,760.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requester provided on the dates above non-preauthorized physical therapy to the claimant on this WorkWell Texas claim. All Texas Mutual network claims require preauthorization for physical medicine unless they are participating through Align, which the requester is not."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 5 – 29, 2018	Outpatient physical therapy	$3,760.00	$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 requirements for prior authorization.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Precertification/authorization/notification absent
   - 193 – Original payment decision is being maintained

Issues

1. Is the requestor's position supported?

Findings

1. The requestor is seeking reimbursement of outpatient physical therapy services rendered from June 5, 2018, through June 29, 2018. The insurance carrier denied as 197 – "Precertification/authorization/notification absent." The requestor states in their position, "Due to no knowledge of claim case open with insurance carrier we fail to obtained authorization for the service provided and for the out of network approval."

   Review of the submitted documentation found a "WorkWell, TX" letter dated May 11, 2018. This letter approved the out of network treatment. Also, the requestor states, "On June 7, 2018 received call from Adjuster (adjuster's name) @ Texas Mutual stating service is under work related injury patient sustained.

   This notification was within one day of the first date of service in dispute.

   28 TAC §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;

   Based on the above, the requestor's position is not supported. Insufficient evidence of compliance with the above stated rule was found, 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 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

		October 10, 2018
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 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.