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
AHMED KHALIFA MD

Respondent Name
HARRIS COUNTY

MFDR Tracking Number
M4-19-0264-01

Carrier's Austin Representative
Box Number 21

MFDR Date Received
September 17, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Preauthorization: If required by Rule 134.600, the pre-authorization number is listed above. If pre-authorization was not performed it is in adherence to Rule 134.600 in that pre-authorization was not required for this CPT code for this service or treatment."

Amount in Dispute: $948.98

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The services provided on date of service March 20, 2018 were facet injections... These services are required to be preauthorized in accordance with Rule 134.600... These injection services were not preauthorized and therefore denial of reimbursement pursuant to lack of preauthorization is appropriate and supported by applicable statute and rule... As such, no further reimbursement is due in this matter."

Response Submitted by: Thornton Biechlin Reynolds & Guerra

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
March 20, 2018	64490-RT, 64491-RT, 64490-LT-50 and 64491-LT-50	$948.98	$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 guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
3. 28 Texas Administrative Code 137.100 sets out the treatment guidelines.
4. 28 Texas Administrative Code §134.203, sets out the for reimbursement for professional medical services.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Payment denied/reduced for absence of precertification/authorization
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
   - 1014 – The attached billing has been re-evaluated at the request of the provider, based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted

Issue(s)

Did the requestor obtain preauthorization for the disputed services?

Findings

The requestor seeks reimbursement for CPT Codes 64490-RT, 64491-RT, 64490-LT-50 and 64491-LT-50 rendered on March 20, 2018. The insurance carrier's position statement states in pertinent part, "The services provided on date of service March 20, 2018 were facet injections to the... These services are required to be preauthorized in accordance with Rule 134.600." Review of the EOBs finds the following denial reduction code(s):

- 197 – Payment denied/reduced for absence of precertification/authorization
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- 1014 – The attached billing has been re-evaluated at the request of the provider, based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted

Per 28 Texas Administrative Code §134.600 "(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 (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 section titled Neck and Upper Back (Acute and Chronic) states that facet injections are not recommended, therefore, preauthorization is required. The Division finds that the requestor submitted insufficient documentation to support that preauthorization was obtained for the disputed services. As a result, the requestor is entitled to $0.00 reimbursement for CPT Codes 64490-RT, 64491-RT, 64490-LT-50 and 64491-LT-50 rendered on March 20, 2018.

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

____________________	____________________	April 18, 2019
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, 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 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.