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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Patient Care Injury Clinic

Respondent Name
Ace American Insurance Co

MFDR Tracking Number
M4-19-0424-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
September 26, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted our bills and proper clinical documentation in a timely fashion. We feel that our facility should be paid according to the workers compensation fee schedule guidelines."

Amount in Dispute: $783.14

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Payment for date of service 11/15/17 has been denied as that date of service was not preauthorized. The last visit that was preauthorized was 11/14/17 as the concluded the 12 visits that were preauthorized."

Response Submitted by: Broadspire

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 14 – 15, 2017	97110, 97140, 97112, G0283	$783.14	$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 of disputed services.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical

services.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P16 – Medical provider not authorized/certified to provider treatment to injured workers in this jurisdiction
   - D37 – Date(s) of service is not authorized. Therefore no allowance is recommended

Issues

1. Is the insurance carrier's reason for denial of payment supported?

Findings

1. The health care provider is seeking additional reimbursement in the amount of $783.14 for physical therapy services rendered on November 14 – 15, 2017. The insurance carrier made a payment for the November 14, 2017 date of service but continues to deny the November 15, 2017 date of service as D37 – "Date(s) of service is not authorized." The health care provider asked to proceed with the review.

   28 TAC 134.600 (p) (5) states in pertinent part,

   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 documentation found a "pre-authorization" from Broadspire dated September 1, 2017 for "Physical therapy, quantity 12 (3x4weeks). The four weeks of this authorization ended on September 30, 2017. The date of service in dispute is November 15, 2017. Insufficient evidence was found to support this date of service received prior authorization as required by 28 TAC 134.600(p)(5)(A). The insurance carrier denial is supported. No additional 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	December 12, 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.