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
Rehab Therapy Resources Inc

Respondent Name
State Office of Risk Management

MFDR Tracking Number
M4-19-1557-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
November 16, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This bill was denied on four separate occasions for "recertification/authorization/notification absent" even though multiple phone calls were made and multiple reconsideration requests with proper documentation were filed with this insurance carrier."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In review of the disputed charges the Office determined that CPT 90853 was not preauthorized under |179451, therefore medical necessity for this procedure code has not been established."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 6 – 28, 2018	90853	$150.00	$127.32

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. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Payment denied/reduced for absence of precertification/authorization

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What rule is applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement in the amount of $150.00 for professional medical services rendered on June 6, 14, 21, and 28, 2018. The insurance carrier denied disputed services with claim adjustment reason code 197 – "Payment denied/reduced for absence of precertification/authorization."

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

   Non-emergency health care requiring preauthorization includes:

   (7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized return-to-work rehabilitation program;

   Review of the submitted information finds a letter with original date of 12/13/2017 and revision date of 4/26/208 with Request ID: 176837 and Authorization # 107965. The preauthorization determination letter allowed CPT 90853 through July 20, 2018. The carrier's denial is not supported the services in dispute will be reviewed per applicable fee guideline.

2. 28 TAC 134.203 (c) states in pertinent part,

   To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor.)

   The Medicare payment policy (fee schedule) at www.cms.gov finds an allowable of $26.20. The allowable multiplied by the Division Conversion factor/Medicare conversion factor or 58.31/35.9996 x $26.20 = $42.44.

3. This allowable is due for date of service June 6, 14, and 28, 2018 for a total of $127.32. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $127.32.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $127.32, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 4, 2019 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.