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
Elite Healthcare North Dallas

Respondent Name
Markel Insurance Co

MFDR Tracking Number
M4-19-2630-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
January 14, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Physical Therapy was approved on 4 units and you are not paying according."

Amount in Dispute: $413.84

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Reimbursement is not owed due to failure of the Requestor to obtain preauthorization for the additional physical therapy services after they completed the six sessions which were preauthorized."

Response Submitted by: Downs Stanford PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 18, 2018	97110, 97112, 97140	$413.84	$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 our requirements of prior authorization.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - C45 – Denied: Per Carrier, pre-authorization not requested

Issues

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

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code C45 – "Denied: Per Carrier, pre-authorization not requested."

   28 Texas Administrative Code §134.600 (p) (5) (A) 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;

   Review of the document titled, "Workers' Compensation Non-Network Utilization Review Partially Approved" page, 2 found, "Recommend six sessions of CPT codes 97110, 97112, and 97140 in any combination not to exceed three to four units per session."

   Based on the above, the approved number of sessions was six not nine. The carriers' 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

		February 7, 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 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.