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
LOUISIANA ORTHOPAEDIC SPECIALISTS

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-19-3597-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
March 26, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I have provided a copy of the Letter from Utilization Review Department stating continuation of Occupational Therapy was approved for 6 certified visits..."

Amount in Dispute: $590.82

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual Insurance has no record the requestor obtained preauthorization for date of service 3/29/18… Texas Mutual concluded the treatment was unrelated to the compensable injury."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
March 29, 2018 to May 15, 2018	Occupational Therapy	$590.82	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §124.2 sets out requirements for carrier reporting and notification.
2. 28 Texas Administrative Code §133.305 sets out general provisions regarding dispute of medical bills.
3. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
4. 28 Texas Administrative Code §134.600 sets out rules regarding preauthorization of health care.
5. 28 Texas Administrative Code §141.1 sets out the procedures for requesting a benefit review conference.
6. Texas Labor Code §408.021 sets out provisions regarding entitlement to medical benefits.
7. Texas Labor Code §413.031 sets out provisions regarding medical dispute resolution.
8. Texas Labor Code Chapter 410 sets out provisions regarding the adjudication of extent and liability disputes.
9. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 18 – EXACT DUPLICATE CLAIM/SERVICE
   - 224 – DUPLICATE CHARGE.
   - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- 197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT
- 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- 878 – APPEAL (REQUEST FOR RECONSIDERATION) PREVIOUSLY PROCESSED. REFER TO RULE 133.250(H)
- 891 – NO ADDITIONAL PAYMENT AFTER RECONSIDERATION
- 930 – PRE-AUTHORIZATION REQUIRED, REIMBURSEMENT DENIED
- 219 – BASED ON EXTENT OF INJURY.
- 246 – THE TREATMENT/SERVICE HAS BEEN DETERMINED TO BE UNRELATED TO THE EXTENT OF INJURY. FINAL ADJUDICATION HAS NOT TAKEN PLACE.

Issues

1. Are there unresolved issues regarding extent of injury?
2. Did the provider fail to obtain preauthorization?

Findings

1. The insurance carrier denied disputed dates of service May 1 to May 15, 2018 with claim adjustment codes:
   - 219 – BASED ON EXTENT OF INJURY.
   - 246 – THE TREATMENT/SERVICE HAS BEEN DETERMINED TO BE UNRELATED TO THE EXTENT OF INJURY. FINAL ADJUDICATION HAS NOT TAKEN PLACE.

   28 Texas Administrative Code §133.305(b) requires that:

   > If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021.

   28 Texas Administrative Code §133.307(e)(3)(H) requires that if the carrier has raised a dispute pertaining to compensability, extent of injury, or liability for the claim, "the Division shall notify the parties of the review requirements pursuant to §124.2 of this title, and will dismiss the request until those disputes have been resolved by a final decision, inclusive of all appeals."

   The appropriate dispute process for unresolved issues of extent of injury requires the health care provider to request a benefit review conference pursuant to 28 Texas Administrative Code §141.1. All outstanding issues regarding compensability, extent of injury, or liability for the disputed services must be resolved before requesting medical fee dispute resolution.

   The provider may make a new request for Medical Fee Dispute Resolution after all outstanding extent, liability and compensability issues have been resolved. Per Rule §133.307(c)(1), the provider may request medical fee dispute resolution up to one year from the date of service. Rule §133.307(c)(1)(B)(i) provides that MFDR requests may be filed later than one year after the date of service if the request is filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability.

   Review of the submitted information finds there are unresolved issues of extent of injury regarding the services in dispute. No documentation was presented to support the issues of extent of injury have been resolved. Accordingly, the MFDR request for service dates May 1 to May 15, 2018 is hereby dismissed.

2. The insurance carrier denied disputed date of service March 29, 2018 with claim adjustment codes:
   - 197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT
   - 930 – PRE-AUTHORIZATION REQUIRED, REIMBURSEMENT DENIED

   Rule §134.600(c) requires that "The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions); (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care."

Rule §134.600(p)(5) states that non-emergency health care requiring preauthorization includes "physical and occupational therapy services."

No documentation was found to support the disputed occupational therapy services were preauthorized. Nor did the requestor present documentation to support a medical emergency. The insurance carrier's denial reasons are supported. Payment is not recommended.

Conclusion

For the reasons stated above, service dates May 1, 2018 to May 15, 2018 are hereby dismissed pending resolution of the extent of injury issues in accordance with Labor Code Chapter 410 processes regarding disputes of liability compensability and extent of injury.

The request for medical fee dispute resolution of date of service March 29, 2018 did not involve any issues of extent of injury and is eligible for review; however, the provider failed to obtain required preauthorization for the non-emergency occupational therapy services performed on March 29, 2018. As a result, no additional payment can be recommended.

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

	Grayson Richardson	April 24, 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.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.