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 FORT WORTH

Respondent Name
LIBERTY MUTUAL FIRE INSURANCE COMPANY

MFDR Tracking Number
M4-19-4938-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
July 22, 2019

Response Submitted By
Liberty Mutual Insurance Company

REQUESTOR'S POSITION SUMMARY

"THIS IS AN INCORRECT DENIAL FORM THE CARRIER. CARRIER IS NOT PAYING ACCORDING TO AUTHORIZATION OUR FACILITY RECEIVED REGARDING THIS PATIENT."

RESPONDENT'S POSITION SUMMARY

"the denial for 97110 stands as Pre-Authorization was not requested for 97110."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
September 6, 2018	Physical Therapy Exercises: 97110	$201.16	$0.00

AUTHORITY

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 §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
3. 28 Texas Administrative Code §134.600 sets out rules regarding preauthorization of health care.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – PRE-AUTHORIZATION WAS REQUIRED, BUT NOT REQUESTED FOR THIS SERVICE PER DWC RULE 134.600.
   - 193 – [A description of this code was not found with the submitted materials.]
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.

Issues

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

Findings

The insurance carrier denied disputed services with claim adjustment reason code:

- 197 – PRE-AUTHORIZATION WAS REQUIRED, BUT NOT REQUESTED FOR THIS SERVICE PER DWC RULE 134.600.

28 Texas Administrative Code §134.600(c)(1) requires the carrier to be liable for medical costs relating to health care only in the case of:

(A) an emergency, as defined in Chapter 133…

(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 the non-emergency health care requiring preauthorization includes "physical and occupational therapy services…" The respondent provided documentation of the provider's request for authorization and the approval for the requested services. Review of the request form and approval letter find that authorization was neither requested nor approved for CPT code 97110. Nor did the requestor present documentation to support a medical emergency. The insurance carrier's denial reason is supported. Reimbursement is not recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above, the division finds the requestor has not established that additional payment is due. As a result, the amount ordered is $0.00.

ORDER

In accordance with Texas Labor Code §413.031, based on the information submitted for review, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	August 2, 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.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). The division must receive the request within twenty days of your receipt of this decision.

The request may be faxed, mailed or personally delivered either to the field office handling the claim or to the division at the contact information listed on the form. You must deliver a copy of the request to all other parties involved in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** together with any other information required by 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.