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
AMERICAN ZURICH INSURANCE CO

MFDR Tracking Number
M4-20-0380-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
OCTOBER 11, 2019

REQUESTOR'S POSITION SUMMARY

"CARRIER IS NOT PAYING ACCORDING TO AUTHORIZATION THAT WAS PROVIDED."

Amount in Dispute: $292.78

RESPONDENT'S POSITION SUMMARY

November 1, 2019: "The carrier has previously reimbursed the provider on that same date of service under CPT code 97112. The carrier is reprocessing the provider's bill and will supplement the response with the additional EOB."

January 31, 2020: "The carrier sent the check out on 11/13/19. But it has not been cashed. The check went to PO Box 1353 Frisco, TX 75034, which is the address that was on the DWC 60."

Responses Submitted By: Flahive, Ogden & Latson

February 10, 2020: "Please find EOB attached."

Response Submitted By: Renee Marquez, Zurich North America

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 13, 2018	CPT Code 97110-GP (X4)	$201.16	$0.00
	CPT Code 97140-GP (X2)	$91.62	$0.00
TOTAL		$292.78	$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 (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307, effective May 31, 2012 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
3. 28 TAC §134.600, effective November 1, 2018, requires preauthorization for specific treatments and services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P6-Based on entitlement to benefits.
   - P2-Not a work related injury/illness and thus not the liability of the workers' compensation carrier.
   - W3-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

Is the requestor entitled to additional reimbursement for physical therapy services rendered on December 13, 2018?

Findings

1. Elite Healthcare Fort Worth (requestor) is seeking medical fee dispute resolution in the amount of $292.78 for physical therapy services, CPT codes 97110 and 97140, rendered on December 13, 2018.
2. American Zurich Insurance Co. (respondent) initially denied reimbursement for the disputed physical therapy services based upon "P6-Based on entitlement to benefits," and "P2-Not a work related injury/illness and thus not the liability of the workers' compensation carrier." The respondent did not maintain the denial and issued payment of $292.78 on November 13, 2019.
3. The DWC finds the respondent changed its original final action and reimbursed the requestor for the disputed amount; therefore, no additional reimbursement can be recommended.

Conclusion

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

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the DWC has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		02/13/2020
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 28 Texas Administrative Code §133.307, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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 with the DWC. **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.