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
Everest Rehabilitation Hospitals

Respondent Name
Service Lloyds Insurance Co

MFDR Tracking Number
M4-20-0711-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
November 18, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Acute inpatient rehabilitation services are justified to restore a disabled person to self-sufficiency or maximal possible functional independence... We request payment for the inpatient room/board and pharmacy as well as the currently approved therapy."

Amount in Dispute: $22,393.59

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...a new decision was completed by UR vendor rereviewed and approved some of the services ... The total additional allowance recommended is now $5,188.43."

Response Submitted by: Avidel

SUMMARY OF FINDINGS

Dates of Service	Disputed	Finding
August 16 – 25, 2019	Services denied for Medical Necessity	DISMISSED due to unresolved issues of medical necessity
August 16 – 25, 2019	Services paid after fee dispute filing	No longer in dispute, paid in full

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 §133.305 sets out the general Medical Dispute Resolution guidelines.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.308 sets out the procedure for Medical Dispute Resolution of Medical Necessity Disputes.

4. The insurance company denied the disputed services with the following remark codes

- 95 – Plan procedures not followed
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- U01 – There was no UR procedure/treatment request received
- U02 – The billed service was reviewed by UR and denied
- UR determined not medically necessary per Pre-Auth #3943253

Findings

1. *Does the medical fee dispute referenced above contain information/documentation that indicates that there are **unresolved** issues of medical necessity?*

Review of the submitted documentation finds documentation to support that an **unresolved** issue of medical necessity exists for certain services. The insurance carrier notified the requestor of such issues in its explanation of benefits (EOB) response(s) during the medical bill review process.

The services denied for medical necessity are;

- Rehab/PVT - $15,975.00
- Pharmacy - $586.00
- Lab/Urology - $126.00
- Pulmonary Function - $518.16

28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding...medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding...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.

The Division hereby notifies the requestor the appropriate process for resolution of an unresolved issue of medical necessity requires filing for an independent review to be conducted by an IRO (independent review organization) appropriately licensed by the Texas Department of Insurance, pursuant to 28 Texas Administrative Code §133.308. Information applicable to HEALTH CARE PROVIDERS on how to file for an IRO may be found at http://www.tdi.texas.gov/hmo/iro_requests.html under ***Health Care Providers or their authorized representatives***.

28 Texas Administrative Code §133.307(f)(3) provides that a dismissal is not a final decision by the Texas Department of Insurance, Division of Workers' Compensation ("Division"). The medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of 28 Texas Administrative Code §133.307. 28 Texas Administrative Code §133.307 (c)(1)(B) provides that a request for medical fee dispute resolution may be filed not later than 60 days after a requestor has received the final decision, inclusive of all appeals.

The Division finds that due to the unresolved medical necessity issues, the medical fee dispute request for rehab/private, pharmacy, lab/urology and pulmonary function is not eligible for review until a final decision has been issued in accordance with 28 Texas Administrative Code §133.308

2. *Are the remaining services still in dispute?*

The requestor is seeking additional reimbursement of inpatient rehabilitation services rendered in August 2019. The insurance submitted an explanation of benefits December 4, 2019 where a payment if $5,188.43 was made that included the full billed amount for the following;

- Physical Therapy - $2,042.43
- Occupation Therapy - $2,102.00
- Speech Pathol - $996.00
- Speech Path/Eval - $48.00

These services are no longer in dispute and will not be considered in this review.

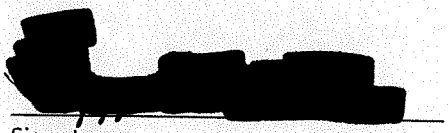
Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution. Even though not all the evidence was discussed, it was considered.

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



Signature

Medical Fee Dispute Resolution Officer

January 23 2020
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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to 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. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.