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
Dallas Testing Inc

Respondent Name
Hartford Casualty Insurance Co

MFDR Tracking Number
M4-20-2796-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
July 29, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The charge does not exceed the fee schedule. I have attached a copy of payment made for the same service without any issues."

Amount in Dispute: $483.36

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider submitted billing for a physical performance evaluation (PPE). This was denied for authorization in accordance with 28 TAC Rule §134.600 as this is the 6th PPE performed."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 5, 2020	97750-GP	$483.36	$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 §134.204 sets the guidelines for workers' compensation specific services.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for prior authorization.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
   - Auth – payment denied/reduced for absence of, or exceeded, pre-certification/authorization. Preauthorization was not obtained and treatment was rendered without the approval of treating doctor.

- 309 – The charge for this procedure exceeds the fee schedule allowance.

Issues

Is the insurance carrier's denial of payment supported?

Findings

The requestor is seeking reimbursement of professional medical services rendered March 5, 2020. The insurance carrier denied the disputed service based on lack of authorization. The requestor states in their position, "This was denied for authorization in accordance with 28 TAC Rule §134.600 as this is the 6th PPE performed."

28 TAC §134.204 (g) states the following applies to Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed.

The insurance carrier supported that six FCEs had been performed which per 28 TAC 134.600 (p) (12) does require prior authorization as the treatment guidelines shown above were exceeded. The denial for lack of authorization is supported. No payment is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC 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 requestor has not established payment 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

		October 19, 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 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.