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
ACE AMERICAN INSURANCE CO

MFDR Tracking Number
M4-21-1285-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
MARCH 29, 2021

REQUESTOR'S POSITION SUMMARY

"These bills were previously submitted in a timely manner. Please review the attached documentation any pay according to the TDI guidelines."

Amount in Dispute: $32.56

RESPONDENT'S POSITION SUMMARY

The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 8, 2020	CPT Code 97110-GP (X6)	$32.56	$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 February 22, 2021 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.600, effective November 1, 2018, requires preauthorization for specific treatments and services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197-Payment denied reduced for absence of, or exceeded, pre-certification/authorization.
   - 00409, 119-Benefit maximum for this time period or occurrence has been reached.
   - 163-The charge for this procedure exceeds the unit value and/or the multiple procedure rules.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

- 5853-The amount paid reflects a fee schedule reduction.
- 5283-Additional allowance is not recommended as the bill was reviewed in accordance with state guidelines, usual and customary policies, providers contract, or carr.

Issues

Is the requestor entitled to additional reimbursement for physical therapy services, CPT code 97110, rendered on July 8, 2020?

Findings

1. The Austin carrier representative for Ace America Insurance Co is Downs & Stanford PC. Downs & Stanford PC received a copy of this medical fee dispute on April 6, 2021. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information

   As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).
2. The requestor is seeking reimbursement in the amount of $32.56 for physical therapy services, CPT codes 97110, rendered on July 8, 2020.
3. The respondent reduced reimbursement for the disputed physical therapy services based upon reason codes "197," "00409," and "119." (description listed above)
4. To determine if the disputed services are eligible for reimbursement the DWC refers to the following statute:

   - 28 TAC §134.600 (p) states,

     Non-emergency health care requiring preauthorization includes: (5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (A) Level I code range for Physical Medicine and Rehabilitation, but limited to: (i) Modalities, both supervised and constant attendance; (ii) Therapeutic procedures, excluding work hardening and work conditioning.

   The DWC finds physical therapy services require preauthorization per rule 134.600.

   - 28 TAC §134.600 (f) states,

     The requestor or injured employee shall request and obtain preauthorization from the insurance carrier prior to providing or receiving health care listed in subsection (p) of this section. Concurrent utilization review shall be requested prior to the conclusion of the specific number of treatments or period of time preauthorized and approval must be obtained prior to extending the health care listed in subsection (q) of this section. The request for preauthorization or concurrent utilization review shall be sent to the insurance carrier by telephone, facsimile, or electronic transmission and, include the:

     (2) specific health care listed in subsection (p) or (q) of this section;

     (3) number of specific health care treatments and the specific period of time requested to complete the treatments.

   The requestor did not submit any preauthorization reports to support the number of treatments preauthorized; therefore, the request for additional reimbursement is not supported.

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 Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		06/04/2021
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.