



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

90DICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

ELITE HEALTHCARE FORT WORTH

Respondent Name

XL INSURANCE AMERICA INC

MFDR Tracking Number

M4-21-1291-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

MARCH 26, 2021

REQUESTOR'S POSITION SUMMARY

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

Amount in Dispute: \$121.84

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
January 13, 2021	CPT Code 97112 Physical Therapy	\$24.34	\$0.00
	CPT Code 97110 Physical Therapy	\$97.50	\$0.00
TOTAL		\$121.84	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 §134.203, 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:
 - P12-Workers' compensation jurisdictional fee schedule adjustment.
 - 309-The charge for this procedure exceeds the fee schedule allowance.
 - 00663-Reimbursement has been calculated according to state fee schedule guidelines.
 - 5403-This bill qualified for the Clinical Validation Program, no reductions applied.
 - 119, 409- Benefit maximum for this time period or occurrence has been reached.
 - 163-Claim/service adjusted because the attachment referenced on the claim was not received.

Issues

Is the requestor due additional reimbursement for physical therapy and evaluation services rendered on January 13, 2021?

Findings

1. The Austin carrier representative for XI Insurance America INC is Flahive, Ogden & Latson. Flahive, Ogden & Latson 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 medical fee dispute resolution in the amount of \$121.84 for CPT codes 97110 and 97112 rendered on January 13, 2021.
3. The respondent reduced reimbursement for the disputed physical therapy services based upon reason codes "409" and "119." (description listed above)

The EOBs refer to a Medicare payment policy regarding Medically Unlikely Edit (MUE). MUE's were implemented by Medicare in 2007. MUE's set a maximum number of units for a specific service that a provider would report under most circumstances for a single patient on a single date of service. Medicare developed MUE edits to detect potentially medically unnecessary services.

Although the DWC adopts Medicare payment policies by reference in applicable Rule §134.203, paragraph (a)(7) of that rule states that specific provisions contained in the Division of Workers' Compensation rules shall take precedence over any conflicting provision adopted the Medicare program.

The Medicare MUE payment policy is in direct conflict with Texas Labor Code §413.014 which requires that all determinations of medical necessity shall be made prospectively or retrospective through utilization review; and with Rule §134.600 which sets out the procedures for preauthorization and retrospective review of professional services such as those in dispute here. The DWC concludes that Labor Code §413.014 and 28 TAC §134.600 take precedence over Medicare MUE's.

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

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

Date

06/04/2021

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, 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 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 MDR 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.