



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Noel Edward Oliveira

Respondent Name

Texas Mutual Insurance Co

MFDR Tracking Number

M4-23-0623-01

Carrier's Austin Representative

Box Number 54

DWC Date Received

November 9, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 16, 2022	Code 11042	\$200.00	\$0.00

Requestor's Position

"Please refer to 2nd appeal letter, DWC Form -060, original EOB, Claim, Medical Records and approval letter which reflects approved non network provider for WorkWell. Thank You"

Amount in Dispute: \$200.00

Respondent's Position

"Per Commission Rule 133.307(d) Texas Mutual submits the following statement in referenc to the dispute of service from 02/16/2022 to 02/16/2022.

This claim is in the WorkWell, TX network and the health care services(s) rendered require preauthorization per Rule 134.600. Texas Mutual has no record that the provider obtained preauthorization.

Response Submitted by: Texas Mutual Workers Compensation Insurance

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.600 sets out the fee guidelines for preauthorization, concurrent utilization review, and voluntary certification of health care.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- CAC-P12 – Workers' Compensation Jurisdictional fee schedule adjustment
- CAC-W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- CAC-197 – Precertification/authorization/notification absent
- DC4 – No additional reimbursement allowed after reconsideration For information all (888) 332-5246
- D25 – Approved non network provider for WorkWell, TX Network claimant per rule 1305.153 (C)
- 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
- 785 - Denied for lack of preauthorization or preauthorization denial in accordance with the network contract

Issues

1. Is Insurance Carrier's denial based on denial for lack of preauthorization supported?
2. Is the Requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement for disputed service code 11042. The insurance carrier denied the service with denial reasons listed above.

28 TAC §134.600 (p) states : Non-emergency health care requiring preauthorization includes:

- (1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay;

- (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section;
- (3) spinal surgery;
- (4) all work hardening or work conditioning services;
- (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;
 - (iii) Orthotics/Prosthetics Management;
 - (iv) Other procedures, limited to the unlisted physical medicine and rehabilitation procedure code; and
 - (B) Level II temporary code(s) for physical and occupational therapy services provided in a home setting;
 - (C) except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following:
 - (i) the date of injury; or
 - (ii) a surgical intervention previously preauthorized by the insurance carrier;
- (6) any investigational or experimental service or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service, or device but that is not yet broadly accepted as the prevailing standard of care;
- (7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized return-to-work rehabilitation program;
- (8) unless otherwise specified in this subsection, a repeat individual diagnostic study:
 - (A) with a reimbursement rate of greater than \$350 as established in the current Medical Fee Guideline; or
 - (B) without a reimbursement rate established in the current Medical Fee Guideline;
- (9) all durable medical equipment (DME) in excess of \$500 billed charges per item (either purchase or expected cumulative rental);
- (10) chronic pain management/interdisciplinary pain rehabilitation;
- (11) drugs not included in the applicable division formulary;

Review of the submitted documentation does not support preauthorization was requested in accordance with 28 TAC §134.600, insurance carrier's denial is supported.

2. Therefore, reimbursement is not recommend for the disputed services as preauthorization was not obtained in accordance with 28 TAC §134.600.

Conclusion

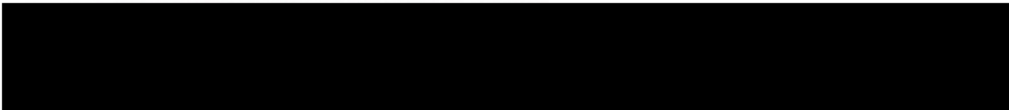
The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature



Signature

Medical Fee Dispute Resolution
Officer

December 20, 2022

Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.

