TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Peak Integrated Healthcare

Respondent Name
Amtrust Insurance Co

MFDR Tracking Number
M4-24-0201-01

Carrier's Austin Representative
Box Number 17

DWC Date Received
September 27, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 29, 2023	97110-GP	$346.86	$0.00
June 29, 2023	97112-GP	$132.76	$0.00
July 13, 2023	97750-GP	$531.04	$0.00
	Total	$1010.66	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a copy of their reconsideration dated September 8, 2023 with a handwritten note dated September 27, 2023 that states, "These denials are incorrect and treatment was authorized for this patients injury. These bills should be paid in full as all documentation is attached,"

Amount in Dispute: $1010.66

Respondent's Position

The Austin carrier representative for Amtrust Insurance Co is Downs Stanford PC. The representative was notified of this medical fee dispute on October 4, 2023.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within

14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

Response submitted by: N/A

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 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.600 sets out requirements of prior authorization.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- 198 – Precertification/notification/authorization/pre-treatment exceeded.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- 95- Plan procedures not followed.
- N54 – Claim information is inconsistent with pre-certified/authorized services.
- U05 – The billed service exceeds the UR amount authorized.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking reimbursement of physical therapy rendered in June and July of 2023, The insurance carrier denied the claim stating the services exceeded the prior authorization, The requestor in support that the services were authorized submitted explanation of benefits for date of service June 28, 2023 and August 15, 2023.

DWC Rule 28 TAC §134.600 (p) (5) Non-emergency health care requiring preauthorization includes… physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS).

The explanation of benefits submitted by the requestor is insufficient to support the dates of service, disputed codes or units were prior authorized. No payment is recommended.

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 reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 15, 2023 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.