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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Doctors Hospital of Laredo

Respondent Name
LM Insurance Corp

MFDR Tracking Number
M4-12-0943-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
November 23, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have found in this audit they have not paid what we determine as "fair and reasonable."

Amount in Dispute: $193.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The billed charges for procedure code 97032 are denied as outside the ODG guidelines. Liberty Mutual's Utilization Review department reviewed the therapy request for (injured worker) and determined that the Official Disability Guidelines does NOT recommend the use of electrical stimulation (97032) or ultrasound (97035)."

Response Submitted by: Liberty Mutual Insurance Co

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 4 – 26, 2011	97032	$55.20	$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.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out procedures for preauthorization, concurrent utilization review, and voluntary certification of health care.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - Z710 – The charge for this procedure exceeds the fee schedule allowance
   - X388 – Pre-authorization was requested but denied for this service per DWC Rule 134.600

Issues

1. Did the requestor support requirements of division rules were met?

2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed services as X388 –"Pre-authorization was requested but denied for this service per DWC Rule 134.600." 28 Texas Labor Code §134.600 (8) states, "Preauthorization: a form of prospective utilization review by a payor or a payor's utilization review agent of health care services proposed to be provided to an injured employee." Review of the submitted documentation finds pre-authorization was requested for the disputed services but denied. Therefore, the carrier's denial is supported.
2. 28 Texas Administrative Code §134.600(5) states, "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;" As the requestor did not have required authorization to provide the service in dispute, no additional payment can be recommended.

Conclusion

For the reasons stated above, the Division 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

		August 19, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.