



# 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

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

TETON HOME HEALTH

**MFDR Tracking Number**

M4-12-2240-01

**MFDR Date Received**

February 28, 2012

**Respondent Name**

INSURANCE CO OF THE STATE OF PA

**Carrier's Austin Representative**

Box Number 19

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "It appears that an IOR was conducted for Dr. Altenberg's office before a request for reconsideration was conducted. The proper sequence of appeals also appears to have not been followed correctly due to the fact that all party's documentation and requests were confused and mixed together. Dr. Altenberg's office, and our office, Teton Home Health's, appeals were not for the same purpose. Dr. Altenberg's office's appeals were in behalf of Outpatient Physical Therapy. Teton Home Health's appeals were for Home Health Physical Therapy... We ask that is please be reviewed and that the Home Health Physical Therapy and Skilled Nursing wound care for the 2 week span please be approved for payment."

**Amount in Dispute:** \$1,997.94

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Chartis request you find that Teton Home Health is not due any reimbursement because an IRO has found that the provided services were not medically necessary."

**Response Submitted by:** Chartis

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 21, 2011 through December 6, 2011	Home Health Physical Therapy Services	\$1,997.94	\$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**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.600 sets out the Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care.
- Neither party provided copies of Explanation of Benefits for review in this dispute.

#### **Issues**

- Did the requestor file for dispute resolution under the administrative remedy outlined in 28 Texas Administrative Code §133.307?
- Did the requestor obtain preauthorization for the disputed services?
- Is the requestor entitled to reimbursement?

**Findings**

1. The requestor provided home health physical therapy services in the state of Idaho on November 21, 2011 through December 6, 2011 to an injured employee with an existing Texas Workers' Compensation claim. The requestor was dissatisfied with the respondent's final action. The requestor filed for dispute resolution under 28 Texas Administrative Code §133.307. The Division concludes that because the requestor sought the administrative remedy outlined in 28 Texas Administrative Code §133.307 for resolution of the matter of the request for additional payment, the dispute is to be decided under the jurisdiction of the Texas Workers' Compensation Act and applicable rules.
2. The requestor seeks reimbursement for home health physical therapy services rendered on November 21, 2011 through December 6, 2011.  
28 Texas Administrative Code §134.600 states in pertinent part, "(p) 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)... (B) Level II temporary code(s) for physical and occupational therapy services provided in a home setting."

Review of the submitted preauthorization letter issued by HDI Health Direct, Inc., dated December 7, 2011, documents that the following:

Date of Request	November 23, 2011
Procedure/Treatment	Home Health Physical Therapy, 3 x 2 x 7 weeks
Date of Decision	December 5, 2011
Outcome	"A peer review has reviewed the proposed medical treatment for the above named patient. This is to notify you that the clinical findings do not appear to support the medical necessity of treatment indicated above..."

3. Review of the submitted documentation does not support that preauthorization was obtained prior to rendering the disputed services. As a result, the requestor is not entitled to reimbursement for the home health physical therapy services in dispute rendered on November 21, 2011 through December 6, 2011.

**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**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
November 19, 2015  
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, 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 Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division 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 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 §141.1(d).

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