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 and Address

HUMPAL PHYSICAL THERAPY
5026 DEEPWOOD CIRCLE
CORPUS CHRISTI TX 78415

Respondent Name
Liberty Insurance Corp

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-13-1585-01

MFDR Date Received
February 25, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "A verbal authorization was given to us on 02/14/12 by Nella P for 10 visits start date 02/14/12 end date 03/13/12."

Amount in Dispute: $1,905.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Charges listed of physical therapy codes 97113, 97032, 97112, and 97002 for dates of service 3/5/12 through 3/13/12 were denied appropriately according to the preauthorization requested and approved. The only error we found was for date of service 3/12/12 where, due to a data error, procedure code 97112 was entered as 97110. The service was paid. We have issued a corrected EOB but no additional reimbursement resulted from the correction."

Response Submitted by: Liberty Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 8 – 13, 2012	Physical Therapy	$1,905.00	$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 a medical fee dispute.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 388 – Pre-authorization was requested but denied for the service per DWC Rule 134.600.
   - B291 – This is a bundled or non-covered procedure based on Medicare Guidelines; No separate payment allowed

- 193 – Original payment decision is being maintained

Issues

1. Did the requestor support the services in dispute were prior authorized?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the services in dispute as, 388- "Pre-authorization was requested by denied for the service per DWC Rule 134.600." Review of the submitted documentation finds a Utilization Management letter from Liberty Mutual Group dated, February 17, 2012, that states in pertinent part, "The guidelines in regard to aquatic therapy (97113) would recommend this therapy, as an option to land/based exercise where reduced weight bearing is desirable such as in extreme obesity, but that has not been documented" and "The guidelines do not recommend electrical stimulation (97032) citing a lack of efficacy for this therapy in the evidence based literature." Therefore; the carrier's denial is supported.
2. Review of the submitted documentation finds 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

Signature	Medical Fee Dispute Resolution Officer	March , 2014 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.