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
Elite Healthcare North Dallas

Respondent Name
Markel Insurance Company

MFDR Tracking Number
M4-14-3115-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
June 12, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached dates of services 10/2/13, 10/3/13, 10/24/13, 10/31/13, 11/6/13 were not paid in full.

Dates 10/2/13 and 10/3/13 were **INITIAL 6** physical therapy sessions. **Per RULE 134.600, the initial 6 physical therapy visits DO NOT REQUIRE PREAUTHORIZATION.** I have **attached a copy of the operative report showing these physical therapy sessions were within two weeks from surgery.** I have also attached that rule 134.600.

Dates of services 10/24/13, 10/31/13, 11/6/13 **were office visits and work status reports.** They are being **incorrectly denied for lack of preauthorization. But, they don't require preauthorization and are required per TDI and ODG Guidelines.** I have attached those rules."

Amount in Dispute: $1358.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "First of all the physical therapy sessions in dispute for 10/2/13 and 10/3/13 have been paid. Enclosed please find the EOBs and payment screen showing payment was made pursuant to the fee guidelines.

For the dates of service 10/24/13, 10/31/13, and 11/6/13, the Requestor billed for office visits and physical therapy. The Requestor sought preauthorization for the physical therapy, and the physical therapy was paid. The office visits were denied as preauthorization was not requested. Respondent contends that preauthorization was required (as all other services billed required preauthorization) and not obtained for the office visits.

Enclosed please find an excerpt from the ODGs Neck Chapter which states that the maximum number of occurrences of CPT code 99213 (the CPT code used by the Requestor for each date of service in dispute) is only 6. As this amount was exceeded over the time-span of the Claimant's claim, the Requestor should have requested preauthorization for treatment of the Claimant.

The medical records also fail to properly document the office visits. The medical records do not document any the following as required by use of CPT code 99213: a problem focused history, a problem focused examination; or a straightforward medical decision making.

In conclusion, no reimbursement is owed as the Requestor failed to seek preauthorization for the treatment prior to performing the treatment and did not properly document the services."

Response Submitted by: Downs-Stanford, PC, 2001 Bryan St., Ste. 4000, Dallas, TX 75201

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 2, 2013 – November 6, 2013	Physical Therapy, Office Visits, and Work Status Reports	$1358.40	$387.66

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 §137.100 establishes the use of *Official Disability Guidelines - Treatment in Workers' Comp* for use in determining treatment guidelines for workers' compensation treatment.
3. 28 Texas Administrative Code §134.600 defines the procedures that require preauthorization.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 852-106 – Denied: Per carrier pre-authorization not requested $0.00

Issues

1. Did the respondent act in accordance with 28 Texas Administrative Code §133.307 (d)(2)(F)?
2. Was preauthorization required for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent's position statement states, "The medical records also fail to properly document the office visits. The medical records do not document any the following as required by use of CPT code 99213: a problem focused history, a problem focused examination; or a straightforward medical decision making."

   28 Texas Administrative Code §133.307(d)(2)(F), effective May 31, 2012, 37 Texas Register 3833, states that "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review."

   A review of the submitted documentation failed to support that the respondent presented this denial reason to the requestor prior to the date that the request for medical dispute resolution was filed with the Division, therefore this newly raised denial reason or defense shall not be considered in this review.
2. 28 Texas Administrative Code §134.600 (p), "Non-emergency health care requiring preauthorization includes: (12) treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier."The *Official Disability Guidelines - Treatment in Workers' Comp* was the commissioner's adopted treatment guidelines per 28 Texas Administrative Code §137.100 (a) effective January 18, 2007, 32 TexReg 163.

   The *2013 Official Disability Guidelines - Treatment in Workers' Comp* (11th Edition) provides the following direction for office visits for the knee, with similar language found in the chapter for the neck: "Recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. **The ODG Codes for Automated Approval (CAA), designed to automate claims management decision-making, indicates the number of E&M office visits (codes 99201-99285) reflecting the typical number of E&M encounters for a diagnosis, but this is not intended to limit or cap the number of E&M encounters that are medically necessary for a particular patient.** Office visits that exceed the number of office visits listed in the CAA may serve as a "flag" to payors for possible evaluation, however, payors should not automatically deny payment for these if preauthorization has not been obtained. *Note:* **The high quality medical studies required for treatment guidelines such as**

ODG provides guidance about specific treatments and diagnostic procedures, but not about the recommended number of E&M office visits" [emphasis added]. A review of the documentation submitted does not indicate that the office visits were found not to be medically necessary. Therefore, preauthorization is not required for the office visits, billed as CPT Code 99213, for 10/24/13, 10/31/13, and 11/6/13.

28 Texas Administrative Code §137.100 (a) excludes return to work pathways used in the *Official Disability Guidelines - Treatment in Workers' Comp.* For this reason, these guidelines cannot be used to determine preauthorization requirements for submission of the Work Status Report (DWC073) billed with CPT Code 99080. This code/service is not listed in 28 Texas Administrative Code §134.600 (p) requiring preauthorization. Therefore, the Work Status Reports billed on 10/24/13 and 11/6/13 do not require preauthorization.

3. Review of the submitted documentation finds that dates of service 10/2/13 and 10/3/13 were paid in full for all billed codes. Therefore, no additional reimbursement is recommended for these dates of service.

   Review of the submitted documentation finds that physical therapy charges for date of service 10/24/13 were paid in full, but additional reimbursement of $119.22 is recommended for CPT Code 99213 and $15.00 for CPT Code 99080.

   Review of the submitted documentation finds that physical therapy charges for date of service 10/31/13 were paid in full, but additional reimbursement of $119.22 is recommended for CPT Code 99213.

   Review of the submitted documentation finds that physical therapy charges for date of service 11/6/13 were paid in full, but additional reimbursement of $119.22 is recommended for CPT Code 99213 and $15.00 for CPT Code 99080.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $387.66.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $387.66 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	December 29, 2014
Signature	Medical Fee Dispute Resolution Officer	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.