



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Peak Integrated Healthcare

**Respondent Name**

Hartford Casualty Insurance Co

**MFDR Tracking Number**

M4-24-2732-01

**Carrier's Austin Representative**

Box Number 47

**DWC Date Received**

August 14, 2024

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 7, 2024	99213	\$185.89	\$0.00
May 7, 2024	99080-73	\$15.00	\$0.00
June 6, 2024	97750-GP	\$557.52	\$0.00
<b>Total</b>		<b>\$758.41</b>	<b>\$0.00</b>

### Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a copy two reconsiderations for the services listed above. Both are dated July 18, 2024 AND 8/14/2024 and states in pertinent parts, "\*\*\*AFTER RECONSIDERATION THESE BILLS ARE STILL NOT BEING PAID STATING "PROCESSED PROPERLY" AND "NON-COVERED CHARGES". THIS IS INCORRECT AND THESE BILLS SHOULD BE PAID AS ALL OTHERS, SEE ATTACHED PAYMENT FOR A 7/1/, AND 7/9/2024 OFFICE VISIT AND THERAPY FOR SAME COMPENSABLE INJURY\*\*."

**Amount in Dispute:** \$758.41

### Respondent's Position

"The original bills for dos 5/7-6/6/24 were received on 5/14/24 and 6/12/24. DOS 5/7/24 paid at

charges in the amount of \$200.89 under control number 220998144 on 5/23/24. DOS 6/6/24 was denied as not approved by adjuster on 7/2/24 under control number 221131382.”

**Response Submitted by:** The Hartford

## Findings and Decision

### Authority

This medical fee dispute is decided according to [Texas Labor Code \(TLC\) §413.031](#) and applicable rules of the Texas Department of Insurance, Division of Workers’ Compensation (DWC).

### Statutes and Rules

1. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.
2. [28 TAC §134.600](#) sets out the requirements of prior authorization.

### Denial Reasons

The insurance carrier [reduced or denied] the payment for the disputed services with the following claim adjustment codes:

- 96 – Non-covered charge(s)
- 133 – The disposition of this claim/service is pending further review.
- NABA – Reimbursement is being withheld as the treating doctor and/or service rendered were not approved based upon handler review.

### Issues

1. Did the respondent support payment made for May 7, 2024 professional services?
2. Was prior authorization required?

### Findings

1. The requestor is reimbursement of professional medical services rendered on May 7, 2024. The insurance carrier submitted an explanation of benefits with a process date of May 23, 2024 that indicates a payment of \$200.89 under control number 220998144.

The DWC finds the submitted evidence supports a payment in the full billed amount was paid. No additional payment is recommended.

2. The requestor is seeking payment of code 97750 -GP – Physical Test or Measurement rendered on June 6, 2024. The insurance carrier denied for lack of handler approval.

DWC Rule §134.600 (p)(12)(5) states in pertinent part, “Non-emergency health care requiring preauthorization includes: (physical and occupational therapy services... (A) Level I code range for Physical Medicine and Rehabilitations”

The requestor's indicated on the medical the GP modifier that is defined as, "Services delivered under physical therapy plan of care,"

The DWC reviewed all the submitted documentation and found insufficient evidence to support the requestor obtained the required prior authorization for the disputed physical therapy service. The insurance carrier's denial is supported.

### 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 requestor has not established that additional 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

September 11, 2024  
\_\_\_\_\_  
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](http://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 three or email [CompConnection@tdi.texas.gov](mailto: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 tres o correo electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).