



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

WEST TEXAS REHAB CENTER

Respondent Name

INDEMNITY INSURANCE CO OF NORTH AMERICA

MFDR Tracking Number

M4-16-0444-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

OCTOBER 19, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "evaluations and re-evaluations do not need pre-cert."

Amount in Dispute: \$200.02

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier maintains the dispute as the service in question wa not pre-authorized. The provider has not submitted documentation to show pre-authorization was obtained."

Response Submitted by: Broadspire

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 30, 2015	CPT Code G8984-GO-CK Carrying, moving and handling objects functional limitation, current status, at therapy episode outset and at reporting intervals	\$.01	\$0.00
	CPT Code 97004-GO Occupational therapy re-evaluation	\$200.00	\$0.00
	CPT Code G8985-GO-CJ Carrying, moving and handling objects, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	\$.01	\$0.00
TOTAL		\$200.02	\$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 §134.203 effective March 1, 2008, sets the reimbursement guidelines for the disputed service.

3. 28 Texas Administrative Code §134.600, effective July 1, 2012, requires preauthorization for specific treatments and services.
4. 28 Texas Administrative Code §137.100, effective January 18, 2007, sets out the use of the treatment guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 790-This charge was reimbursed in accordance to the Texas medical fee guideline.
 - D49-Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.
 - P12-Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. Does code 97004-GO require preauthorization?
2. Is the requestor entitled to reimbursement for codes G8984-GO-CK and G8985-GO-CJ?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for the disputed occupational therapy re-evaluation based upon a lack of preauthorization.

28 Texas Administrative Code §134.600(p)(12) states “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. This requirement does not apply to drugs prescribed for claims under §§134.506, 134.530 or 134.540 of this title (relating to Pharmaceutical Benefits).”

The requestor billed CPT code 97004-GO, G8984-GO-CK, and G8985-GO-CJ for the diagnosis 727.04-Radial styloid tenosynovitis.

According to the Official Disability Guidelines (ODG), occupational therapy re-evaluation is not recommended treatment for Radial styloid tenosynovitis five years post-injury; therefore, the disputed service required preauthorization.

There is no evidence submitted, that the requestor obtained preauthorization in accordance with 28 Texas Administrative Code §134.600(p)(12). As a result, a preauthorization issue exists and reimbursement is not recommended.

2. On the disputed date of service, the requestor billed CPT code 97004-GO, G8984-GO-CK, and G8985-GO-CJ. Per Medicare guidelines, CPT codes G8984 and G8985, are status “Q-Therapy functional information codes” and are not reimbursable.

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	Date
		11/13/2015

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.