



# TEXAS DEPARTMENT OF INSURANCE

## Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

EAST EL PASO PHYS MED CTR

**Respondent Name**

El Paso County

**MFDR Tracking Number**

M4-16-2142-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

March 28, 2016

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "It is our position that the Hospital should not be prohibited from receiving reimbursement under the fee guidelines because it provided the medically necessary procedures to which the patient is entitled to."

**Amount in Dispute:** \$4,450.00

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Please see the enclosed preauthorization #FA205616. The provider requested 10-15 sessions of CPT codes 97110, 97112, 97035 and 97014. Preauthorization was given for 10 sessions of CPT codes 97110 and 97112. CPT codes 97014 and 97035 are not recommended per the OGD guidelines. CPT code 97124 was not included in the provider's treatment plan that was provided with the request for preauthorization. No additional reimbursement is recommended for CPT codes 97035GP, 97124, and G0283."

**Response Submitted by:** Argus Services Corporation, 4100 Piedras Drive East Ste 251, San Antonio, TX 78228

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 18, 2015 through June 16, 2015	Physical Therapy Services	\$4,450.00	\$0.00

#### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 requirements for prospective and concurrent review of health care.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
- 39B – Services denied at the time authorization/re-certification was requested.
  - 198C – Precertification/authorization exceeded.

**Issues**

1. Are the insurance carrier’s reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

**Findings**

1. The insurance carrier denied disputed services with claim adjustment reason code 39B – “Services denied at the time authorization/re-certification was requested” and 198C – “Precertification/authorization exceeded.” 28 Texas Administrative Code §134.600(p) requires that,

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) at the following levels:

(A) Level I code range for Physical Medicine and Rehabilitation, but limited to:

- (i) Modalities, both supervised and constant attendance;
- (ii) Therapeutic procedures, excluding work hardening and work conditioning;

Review of the submitted information finds:

- Argus Services Corporation – Page 1, Reviewer comments: ...Approved CPT codes: 97110, 97112. Any combination of the approved CPT codes. Not to exceed 60 minutes per session and to transition to HEP. CPT codes 97014 and 97035 are not recommended by ODG Guidelines. DOS Range: 5/14/15 thru 6/19/15.

The services in dispute are HCPCS codes: 97035GP, 97124GP, G0283, for dates of service May 18, 2015 through June 16, 2015. Based on the above, the insurance carrier’s denial reason is supported. Additional reimbursement cannot be recommended.

2. The Division finds no additional reimbursement can be recommended as the requirements of Rule 134.600(p)(5) were not met.

**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 additional reimbursement for the services in dispute.

**Authorized Signature**

\_\_\_\_\_  
Signature

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

\_\_\_\_\_  
April 8, 2016  
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, 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 MFDR 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.**