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
DALLAS TESTING INC

MFDR Tracking Number
M4-18-3304-01

MFDR Date Received
May 14, 2018

Respondent Name
OLD REPUBLIC GENERAL INSURANCE

Carrier's Austin Representative
Box Number 44

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The patient has had physical evaluations done without preauthorization and they have been paid in full. Therefore, this claim should be PAID IN FULL."

Amount in Dispute: $88.04

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It has been determined that ESIS Med Bill Impact will stand on the original recommendation of $0. Treatment is outside ODG. Precertification/authorization/notification absent."

Response Submitted by: ESIS

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
October 5, 2017	97164	$88.04	$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 medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197 – Preauthorization/authorization/certification absent
   - 2 – This procedure on this date was previously reviewed
   - 2 – No proof of pre-auth

Issues

1. What is the AMA CPT Code description for CPT Code 97164?
2. Did the requestor obtain preauthorization for the disputed services?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor billed HCPCS / CPT Code(s) 97164 rendered on October 5, 2017. The insurance carrier in the position summary states in pertinent part, "It has been determined that ESIS Med Bill Impact will stand on the original recommendation of $0. Treatment is outside ODG. Precertification/authorization/notification absent."

   The requestor states in pertinent part, "The patient has had physical evaluations done without preauthorization and they have been paid in full. Therefore, this claim should be PAID IN FULL."

   28 Texas Administrative Code §134.203 (b) states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   The requestor billed CPT Code 97164. The AMS CPT Code descriptor defines this code as "Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures is required; and Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome Typically, 20 minutes are spent face-to-face with the patient and/or family."

2. 28 Texas Administrative Code §134.600 (p) (7) states in pertinent part "(p) Non-emergency health care requiring preauthorization includes... (7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or division exempted return-to-work rehabilitation program."

   28 Texas Administrative Code §134.600 (c) (1) (B) states in pertinent part, "(c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur... (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care..."

   Review of the submitted documentation does not support that the requestor obtained preauthorization for the disputed service, as required by 28 Texas Administrative Code §134.600. As a result, reimbursement cannot be recommended for the disputed CPT Code 97164 rendered on October 5, 2017.

3. Review of the submitted documentation finds that the requestor submitted insufficient documentation to support that preauthorization was obtained for the disputed CPT Code 97164 rendered on October 5, 2017. As a result, reimbursement cannot be recommended for the disputed service.

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	August 16, 2018 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).