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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Health Rockwall

Respondent Name
East Tx Educational Ins Assn

MFDR Tracking Number
M4-19-3020-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
February 4, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Attached is the authorization which includes CPT 97140 which was not paid. Please review and reimburse accordingly."

Amount in Dispute: $156.69

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We were billed 4 units of 97110, 1 unit of 97140 and 1 unit of G0283 for date of service 7/11/18. Based on the preauthorization we allowed the 4 units of 97110. We denied the 97140 due to exceeding authorization and denied G0283 as not authorized. For dates of service 7/23/18 and 7/25/18 we were billed 4 units of 97110 each and 1 unit of 97140 each. We paid the 4 units of 97110 for each date of service and denied 97140 due to exceeding preauthorization, for each date of service. It is our position is that the payment issued was correct, and no further reimbursement is due."

Response Submitted by: Claims Administrative Services Inc

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 11 – 25, 2018	Physical Therapy Services	$156.69	$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

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 requirements for prior authorization.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Precertification/authorization/notification absent

- 198 – Precertification/authorization/notification exceeded

Issues

1. Are the insurance carrier's reasons for denial of payment supported?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 197 – "Precertification/authorization/notification absent" and 198 – "Precertification/authorization/notification exceeded."

   28 Texas Administrative Code §134.600 (p) (5) states in pertinent part,

   > 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;

   Review of the submitted information finds that "Workers Compensation Non-Network Utilization Review Partially Approved" dated June 7, 2018 states:

   > "Determination: Per ODG guidelines I can recommend 1 visit for CPT code 97164 plus 12 visits for CPT codes 97110, 97140, 97530, 97010 and 29240, **not to exceed 4 units per session**." **Exclude code: G0283**

   The disputed services from July 11, 2018 include 97140 and G0283. Four units of 97110 was paid on September 13, 2018. The carrier's denial of "authorization exceeded" is supported. The code G0283 was not authorized. The carrier's denial of "authorization absent" is supported.

   The disputed service 97140 on July 23, 2018 and July 25, 2018. Four units of code 97110 was paid for both service dates on September 13, 2018. The carrier's denial of "authorization exceeded" is supported. No additional payment is recommended.

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 on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

______________________	______________________	February 15, 2019
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 Rule §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 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. **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.