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
UT HEALTH EAST TEXAS REHAB

Respondent Name
ACE AMERICAN INSURANCE COMPANY

MFDR Tracking Number
M4-19-3991-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
April 29, 2019

Response Submitted By
Liberty Mutual Insurance

REQUESTOR'S POSITION SUMMARY

[The requestor did not submit a position statement for consideration in this review.]

RESPONDENT'S POSITION SUMMARY

"denial for G0283 stands with Pre-Authorization was requested by denied. On August 30, 218, ETMC requested approval for 97110, 97140, G0283 which was denied… On September 5, 2018, the provider submitted a correct approval request for CPT codes 97110 and 97140 which UM was approved at that time."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
September 10, 2018 to September 28, 2018	Outpatient Hospital Services	$210.87	$0.00

AUTHORITY

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and 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 §134.403 sets out the hospital facility fee guideline for outpatient services.
3. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
4. 28 Texas Administrative Code §134.600 sets out requirements regarding authorization of health care.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 5882 – PRE-AUTHORIZATION WAS REQUESTED BUT DENIED FOR THIS SERVICE PER DWC RULE 134.600.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
   - 39 – [No description of this code was found with the submitted materials.]
   - 193 – [No description of this code was found with the submitted materials.]

Issues

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

Findings

The insurance carrier denied disputed services with claim adjustment reason code 5882 – "Pre-authorization was requested but denied for this service per DWC Rule 134.600."

Rule §134.600(c)(1) requires the insurance carrier be liable for medical costs relating to health care listed in subsection (p) only in the case of an emergency or when:

> (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care

Rule §134.600(p) states that non-emergency health care requiring preauthorization includes:

> (5) physical and occupational therapy services

The requestor did not present any information to support that preauthorization had been obtained for code G0283.

The respondent provided information to support that the health care provider requested preauthorization, but that authorization was initially denied. The provider submitted a second request for preauthorization that was approved, but which did not contain a request for approval of code G0283.

Based on the information submitted for review, the insurance carrier's denial reasons are supported. Additional reimbursement cannot be recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

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

In accordance with Texas Labor Code §413.031, based on the information submitted for review, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Grayson Richardson Medical Fee Dispute Resolution Officer	May 16, 2019 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.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). The division must receive the request within twenty days of your receipt of this decision.

The request may be faxed, mailed or personally delivered either to the field office handling the claim or to the division at the contact information listed on the form. You must deliver a copy of the request to all other parties involved in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** together with any other information required by 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.