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
BAPTIST ST ANTHONYS HEALTH

Respondent Name
DEEP EAST TEXAS SELF INSURANCE

MFDR Tracking Number
M4-20-1739-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
March 16, 2020

Response Submitted By:
IMO

REQUESTOR'S POSITION SUMMARY

The requestor did not submit a position summary for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

RESPONDENT'S POSITION SUMMARY

"Based on the submitted documentation we are standing on our original recommendation. The Pre-Authorization Determination Letter authorized a combined total of 4 units per session for 6 sessions over a 3-week period. Dates of Service 7/11, 7/16, 7/18 exceeded the authorized amount. A copy of the Pre-Authorization Determination Letter is attached for your reference."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 2, 2019 through July 18, 2019	97110-GP	$381.43	$0.00

FINDINGS AND DECISION

This medical fee dispute is decision pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307, effective May 31, 2012 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.600, effective November 1, 2018, requires preauthorization for specific treatments and services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - 119 - BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED.
    - 163 - THE CHARGE FOR THIS PROCEDURE EXCEEDS THE UNIT VALUE AND/OR THE MULTIPLE PROCEDURE RULES.
    - 170 - REIMBURSEMENT IS BASED ON THE OUTPATIENT/INPATIENT FEE SCHEDULE.
    - 198 - PAYMENT DENIED/REDUCED FOR EXCEEDED PRECERTIFICATION/AUTHORIZATION.
    - P12 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT

Issues

Is the Insurance carrier's denial reason supported?

Findings

The requestor is seeking reimbursement of CPT Code 97110-GP rendered on July 2, 2019 through July 18, 2019. The insurance carrier denied the disputed services based on precertification/authorization denied or exceeded.

28 TAC 134.600 (p) (5) states in pertinent part non-emergency health care requiring preauthorization includes physical and occupational therapy services. Review of the submitted documentation found insufficient evidence to support the dates of service in dispute were preauthorized.

The DWC finds that the insurance carrier's denial reason is supported. As a result, the requestor is not entitled to reimbursement for CPT Code 97110-GP rendered on July 2, 2019 through July 18, 2019

Conclusion

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 DWC finds that the requestor has not established that 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

		November 5, 2020
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 28 TAC §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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed, or personally delivered to the DWC 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 DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.