Division of Workers' Compensation

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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
TEXAS HEALTH HUGULEY

Respondent Name
DALLS COUNTY COMMUNITY COLLEGE

MFDR Tracking Number
M4-22-0852-01

Carrier's Austin Representative
Box Number 17

DWC Date Received
January 4, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 13, 2021 through April 29, 2021	97110 and 97140	$699.85	$0.00
	Total	$699.85	$0.00

Requestor's Position

"Per EOB received bill denied for payment due to preauthorization. Please note, per the adjuster, Jane Smelser with Claims Ad min Services, physical therapy continued treatment was approved as reasonable and necessary, under Precertificatin[sic]# 133616. Please reprocess and remit payment for amount due."

Amount in Dispute: $699.85

Respondent's Position

"The Provider documents they spoke to Jane Smelser and she advised Jane approved the continued therapy under UR number 133616. The DOS in question are 4/13-4/29/2021. Jane Smelser retired from Claims Administrative Services in February of 2021, so she was not in the office to approve these dates of service. In addition, UR number 133616 was an Adverse Determination. Attached is a copy of the Adverse Determination dated 4/5/2021."

Response Submitted by: Claims Administrative Services, Inc.

Findings and Decision

Authority

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

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.600 sets out the guidelines for preauthorization, concurrent utilization review, and voluntary certification of health care.

Denial Reasons

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:

- 721 - PER RULE 134.600 OF THE TEXAS ADMINISTRATIVE CODE, THIS PROCEDURE REQUIRES PREAUTHORIZATION. PREAUTHORIZATION NOT OBTAINED.
- 197 - PRECERTIFICATION/AUTHORIZATION/ NOTIFICATION/PRE-TREATMENT ABSENT.
- W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

1. Is the Insurance Carrier's denial reason(s) supported?
2. Is the Requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Codes 97110 and 97140 rendered on April 13, 2021 through April 29, 2021 in an outpatient facility. The insurance carrier denied/reduced the services in dispute with reduction codes 721 and 197.

   28 TAC 134.600 (p)(2) states, "(2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section…"

   28 TAC 134.600 (p)(5) states, "physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS)…"

   Review of the documentation finds that the requestor submitted insufficient documentation to support that preauthorization was obtained for the outpatient facility charges.

2. The DWC finds that the preauthorization was required for the services in dispute pursuant to 28 TAC 134.600 (p)(2) and 28 TAC 134.600 (p)(5). As a result, reimbursement is not recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

The DWC finds the requester has not established that reimbursement of $0.00 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to reimbursement for the disputed service.

Authorized Signature

______________________	______________________	February 11, 2022
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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.