TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
ST JOSEPH MEDICAL CENTER

Respondent Name
CITY OF HOUSTON

MFDR Tracking Number
M4-22-1060-01

Carrier's Austin Representative
Box Number 29

DWC Date Received
February 2, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 22, 2021	97110-GP, 97530-GP, and 97161-GP	$175.69	$0.00
	Total	$175.69	$0.00

Requestor's Position

"The bill remains unpaid per Texas Fee Schedule calculations."

Amount in Dispute: $175.69

Respondent's Position

"...a preauthorization request was not received to review for medical necessity. Therefore, the fees were denied based on the lack of preauthorization. No additional allowance will be made at this time."

Response Submitted by: IMO

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 preauthorization, concurrent utilization review and voluntary certification guidelines.

Denial Reasons

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

- 197 – Precertification/authorization/notification absent.
- Note – Charges exceeds Fee Schedule allowance.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3 – TOI Level 1 Appeal means a request for reconsideration under 133.250 of this title or an appeal of an adverse determination under Chapter 19, Subchapter U of this title.
- Notes: *Processed as a Reconsideration of EOB 3129314.

Issues

1. Did the Requestor obtain preauthorization for the physical therapy services in dispute?
2. Is the Requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Codes 97110-GP, 97530-GP and 97161-GP rendered on June 22, 2021. The insurance carrier denied the services in dispute with denial reason code 197 (description provided above.)

   Per 28 TAC §134.600 (p)(2) states, (p) Non-emergency health care requiring preauthorization includes… (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section…"

   Per 28 TAC §134.600 (p)(5), (p) Non-emergency health care requiring preauthorization includes… (5) physical and occupation therapy services…"

   Review of the documentation submitted by the requestor finds insufficient documentation to support that preauthorization was obtained for the physical therapy services in dispute. As a result, reimbursement cannot be recommended.

2. The DWC finds that preauthorization was required for the physical therapy services in dispute. As a result, reimbursement cannot be recommended for CPT Codes 97110-GP, 97530-GP and 97161-GP rendered on June 22, 2021.

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 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 services.

Authorized Signature

		March 3, 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.