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
Peak Integrated Healthcare

Respondent Name
Carolina Casualty Insurance Co

MFDR Tracking Number
M4-22-1209-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
February 21, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 29, 2021	97110-GP	$107.84	$0..00
November 19, 2021	97110-GP	$107.84	$0.00
	Total	$215.68	$0.00

Requestor's Position

The requestor did not submit a position statement but did submit a copy of their reconsideration that states, "The above dates of service were denied again due to "previously paid." This is incorrect. We have not been paid for these dates and codes of service."

Amount in Dispute: $215.68

Respondent's Position

"Our initial response to the above referenced medical fee dispute is as follows: we have escalated the bills in question for manual review to determine if additional monies are owed. Supplemental response will be provided once the bill auditing company has finalized their review."

Response submitted by: Gallagher Bassett

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.

Denial Reasons

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

- 90147 – Clam not covered by this payer/contractor. You must send the claim to the correct payer/contractor
- 109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor
- ZK10 – A payment or denial has already been recommended for this service

Issues

1. Is the insurance carrier's denial supported?

Findings

1. The requestor is seeking reimbursement of physical therapy services rendered in October and November of 2021. The insurance carrier denied the charges as not covered by this payer.

   Review of the original explanation of benefits in December 2021 found the claims were denied as not covered by this payer/contractor. The explanation of benefits for the reconsideration in February of 2022 indicates the charges were previously reviewed.

   DWC Rule 28 TAC §133.307(c)(N)(i) states in pertinent part the request must include a position statement of the disputed issue(s) that shall include the requestor's reasoning for why the disputed fees should be paid.

   Review of the submitted documentation found insufficient evidence from the requestor to support the claim was submitted to the correct workers' compensation payer. The insurance carrier's denial is supported. No payment is 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.

DWC finds the requester has not established that additional reimbursement is due.

Order

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

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 23, 2022 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.