Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address:	MFDR Tracking #: M4-10-3514-01
INTEGRA SPECIALTY GROUP, P.A. 517 N. CARRIER PARKWAY, SUITE G GRAND PRAIRIE, TX 75050	DWC Claim #:
	Injured Employee:
	Date of Injury:
Respondent Name and Carrier's Austin Representative Box #:	Employer Name:
TRINITY UNIVERSAL INSURANCE CO Box #: 19	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

The requestor did not submit a position statement in accordance with rule §133.307. The following is taken from the DWC-60 table of disputed services: "Pre-Authorization #5757583. Pre-Authorization #6283261."

Amount in Dispute: $1,685.28

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider submitted a request for medical dispute resolution on March 31, 2010 for healthcare services provided from April 29 through August 19, 2009 and is seeking reimbursement in the amount of $1,685.28. The carrier submitted an original EOB and a reconsideration EOB. The reconsideration EOB incorrectly identified the denial reason. The carrier relies upon its original EOB which stated that the provider performed healthcare services for a non-compensable injury or condition. The carrier filed a notice of dispute on August 1, 2006 identifying the nature of the June 21, 2006 work-related injury as a thoracic sprain/strain. The hearing officer in the April 2, 2008 contested case hearing determined that the June 21, 2006 compensable injury does not include depression or anxiety. The Division appointed Dr. Culver to perform a designated doctor exam to determine the nature and the extent of the Jun 21, 2006 compensable injury. Dr. Culver concluded that the injured worker suffered a thoracolumbar strain which resolved within 3 to 6 months following the date of injury. Dr. Culver also certified that the injured worker reach {sic} MMI on November 30, 2006. Therefore, the healthcare services provided by the provider from April 29 through August 19, 2009 would be for a non-compensable condition or injury. As such, the carrier is not liable for these services even if these services were medically necessary. See 28 TAC §134.600(d)."

Response Submitted by: Trinity Universal, c/o Flahive, Ogden & Latson, 504 Lavaca Suite 100, Austin, TX 78701

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
4/29/09	90806	N/A	$140.44	$0.00
5/7/09	90806	N/A	$140.44	$0.00
5/18/09	90806	N/A	$140.44	$0.00
5/27/09	90806	N/A	$140.44	$0.00
6/24/09	90806	N/A	$140.44	$0.00
7/2/09	90806	N/A	$140.44	$0.00
7/10/09	90806	N/A	$140.44	$0.00
7/17/09	90806	N/A	$140.44	$0.00
7/22/09	90806	N/A	$140.44	$0.00
7/28/09	90806	N/A	$140.44	$0.00

8/11/09	90806	N/A	$140.44	$0.00
8/19/09	90806	N/A	$140.44	$0.00
			Total Due:	$0.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of health care.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 6/17/2009, 8/26/2009, 9/1/2009 and 10/6/2009

   - 219 – Based on extent of injury.
   - 880-125 – Denied per Insurance: NC (non-covered) procedure or service.

   Explanation of benefits dated 3/18/2010

   - 50 – These are non-covered services because this is not deemed a "medical necessity" by the payer.
   - 855-019 – Unnecessary treatment.

Issues

1. Are there unresolved extent of injury issues?
2. Is the insurance carrier's denial of "medical necessity" supported?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor billed CPT code 90806 (individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient) on the above listed dates of service. The insurance carrier denied these services on the original EOB's with reason code "219-Based on extent of injury". Division records support that a Contested Case Hearing (CCH) Decision and Order signed on 4/8/2008 by the hearing officer supports that "Carrier accepted a June 21, 2006 compensable injury in the form of a lumbar strain/sprain and a thoracic strain/sprain. The compensable injury does not include or extend to include depression and anxiety". Division records further support that an appeals panel decision rendered on 6/19/2008 affirmed the hearing officers Decision and Order. Pursuant to rule §134.600(d) The carrier is not liable under subsection (c)(1)(B) or (C) of this section if there has been a final adjudication that the injury is not compensable or that the health care was provided for a condition unrelated to the compensable injury.
2. In addition, the insurance carrier denied the services upon reconsideration with reason code "50-These are non-covered services because this is not deemed a "medical necessity" by the payer". Pursuant to 28 Tex. Admin Code §134.600(c), the carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care. The requestor sought and received preauthorization for the services in dispute; therefore, establishing medical necessity. The insurance carrier's denial of not medically necessary is not supported.
3. The extent of injury issues were resolved at the time the services were rendered and therefore, reimbursement to the requestor for CPT code 90806 for the above listed dates of service is not recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has failed to establish that reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

		6/29/11
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

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