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
NUEVA VIDA BEHAVIORAL HEALTH AND ASSOC

Respondent Name
BEXAR COUNTY

MFDR Tracking Number
M4-13-0558

Carrier's Austin Representative
Box Number 29

MFDR Date Received
OCTOBER 25, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Nueva Vida obtained preauthorization for 6 sessions of individual psychotherapy on 11/28/11."

Amount in Dispute: $625.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 15, 2011 December 16, 2011 December 22, 2011 December 29, 2011 January 20, 2011	CPT Code 90806	$625.00	$0.00

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 Texas Administrative Code §133.305 sets out the general Medical Dispute Resolution guidelines.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.308 sets out the procedure for Medical Dispute Resolution of Medical Necessity Disputes.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 50-These are non-covered services because this is not deemed a medical necessity by the payer.
   - 39-Services denied at the time authorization/precertification was requested.
   - W1-Workers compensation jurisdictional fee schedule adjustment.
   - At the payers request no allowance was made.
   - 14-The date of birth follows the date of service.
   - This procedure on this date was previously reviewed.

- 18-Duplicate claim/service.
- B13-Previously paid. Payment for this claim/service may have been provided in a previous payment.
- 197-Pre-certification/authorization/notification absent.

Issues

1. Does a preauthorization issue exist in this dispute?
2. Does a medical necessity issue exist in this dispute?
3. Are the disputed services eligible for review by Medical Fee Dispute Resolution?

Findings

1. According to the submitted explanation of benefits, the respondent denied reimbursement for CPT code 90806 rendered on December 16, 22, and 29, 2011 based upon a lack of preauthorization.

   The requestor states that "Nueva Vida obtained preauthorization for 6 sessions of individual psychotherapy on 11/28/11." In support of the position, the requestor submitted a copy of an Independent Review Organization decision.

   28 Texas Administrative Code §133.308 (f)(2)(A) states, "health care providers, or qualified pharmacy processing agents acting on behalf of a pharmacy, as described in Labor Code §413.0111, for preauthorization, concurrent, and retrospective medical necessity dispute resolution." A review of the submitted documentation finds that the requestor requested an IRO review for preauthorization denial of six (6) sessions of individual psychotherapy.

   In accordance with 28 Texas Administrative Code §133.308, TDI scheduled an IRO review with True Resolutions Inc. for a preauthorization dispute regarding six (6) sessions of individual psychotherapy to be performed over a eight week period.

   28 Texas Administrative Code §133.308 (o)(1)(C) states that the IRO decision must include: "an analysis of, and explanation for, the decision, including the findings and conclusions used to support the decision."
   A review of the IRO report finds inconsistencies that are somewhat unclear on the outcome. For example, under the heading the Review Outcome, the IRO indicated that the previous adverse determination should be overturned. However, under the Analysis and Explanation of the Decision including Clinical Basis, Findings and Conclusions used to Support the Decision heading, the IRO wrote "Based on the clinical information provided, the request for individual psychotherapy 6 sessions over 8 weeks is not recommended as medically necessary, and the two previous denials should be upheld on IRO," as well as, "Given the lack of significant psychological indicators as well as lack of psychotrophic medications, the requested individual psychotherapy is not indicated as medically necessary." The Division concludes that the analysis, explanation, findings and conclusion indicate that the IRO concluded that the six (6) sessions of individual psychotherapy were not medically necessary; therefore, a preauthorization issue exists in this dispute.
2. According to the submitted explanation of benefits, the respondent denied reimbursement for CPT code 90806 rendered on December 15, 2011 and January 20, 2012 based upon not medically necessary.

   As stated above, the IRO found that the six (6) sessions of individual psychotherapy were not medically necessary; therefore, the respondent's denial is supported.
3. The medical fee dispute referenced above contains information/documentation that indicates that there are **unresolved** issues of medical necessity for the same service(s) for which there is a medical fee dispute. Review of the EOBs presented by the both the requestor and respondent indicate denial reason code "50" and "T13" were used to deny reimbursement for CPT code 99203.

   Resolution of a Medical Necessity Dispute. The Division hereby notifies the requestor the appropriate process for resolution of an unresolved issue of medical necessity requires filing for an independent review to be conducted by an IRO (independent review organization) appropriately licensed by the Texas Department of Insurance, pursuant to 28 Texas Administrative Code §133.308. The submitted documentation finds that an IRO review was conducted in accordance with 28 Texas Administrative Code §133.308.

   If a party is dissatisfied with the outcome of the IRO review, the appeal process is outlined in 28 Texas Administrative Code §133.308(s)(1)(A) which states:

   > A decision issued by an IRO is not considered an agency decision and neither the department nor the division is considered a party to an appeal. In a division Contested Case Hearing (CCH), the party appealing the IRO

decision has the burden of overcoming the decision issued by an IRO by a preponderance of evidence based medical evidence. A party to a medical dispute that remains unresolved after a review under Labor Code §504.053(d)(3) or Insurance Code §1305.355 is entitled to a contested case hearing in the same manner as a hearing conducted under Labor Code §413.0311. A party to a medical necessity dispute may seek review of a dismissal or decision at a division CCH as follows:

(1) A party to a medical necessity dispute may appeal the IRO decision by requesting a division CCH conducted by a division hearing officer. A benefit review conference is not a prerequisite to a division CCH under this subsection.

(A) The written appeal must be filed with the division's Chief Clerk of Proceedings no later than the later of the 20th day after the effective date of this section or 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the division. Requests that are timely submitted to a division location other than the division's Chief Clerk of Proceedings, such as a local field office of the division, will be considered timely filed and forwarded to the Chief Clerk of Proceedings for processing; however, this may result in a delay in the processing of the request.

The Division finds no documentation to support that the adverse IRO decision was appealed to a Contested Case Hearing in accordance with 28 Texas Administrative Code §133.308(s)(1)(A).

Notice of Dispute Sequence. 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding…medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding…medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021.

The medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of 28 Texas Administrative Code §133.307. 28 Texas Administrative Code §133.307 (c)(1)(B) provides that a request for medical fee dispute resolution may be filed not later than 60 days after a requestor has received the final decision, inclusive of all appeals.

The division finds that due to the unresolved medical necessity issues, the medical fee dispute request for code 90806 is not eligible for review in medical fee dispute resolution.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

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.

Authorized Signature

		10/09/2015
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 Texas Administrative Code §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 Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division 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 Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

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