



# Texas Department of Insurance

## Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48  
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645  
512-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

Nueva Vida Behavioral Health and Associates

**Respondent Name**

University Health System

**MFDR Tracking Number**

M4-13-1265-01

**Carrier's Austin Representative**

Box Number 16

**MFDR Date Received**

January 22, 2013

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "...we are the referring HCP and we are billing for case management service... ..we are within the medical fee guidelines to bill for this service."

**Amount in Dispute:** \$28.00

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** Written acknowledgement of medical fee dispute received however, no position statement submitted.

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 19, 2012	99361	\$28.00	\$0.00

#### 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**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.204 sets out the reimbursement guidelines for case management services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
  - B12 – Services not documented in patients medical records
  - 193 – Original payment decision is being maintained. This claim was processed properly the first time

**Issues**

- Did the requestor submit required documentation as required by rule 134.204?
- Is the requestor entitled to reimbursement?

**Findings**

- 1. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier’s Austin representative box, which was acknowledged as received on January 29, 2013. The insurance carrier did not submit a response for consideration in this review. Per the Division’s former rule at 28 Texas Administrative Code §133.307(d)(1), effective May 25, 2008, 33 *Texas Register* 3954, “If the Division does not receive the response information within 14 calendar days of the dispute notification, then the Division may base its decision on the available information.” Accordingly, this decision is based on the available information
- 2. The carrier denied the disputed services as, B12 – “Services not documented in patients medical records.” 28 Texas Labor Code §134.204(e)(4) states in pertinent part, “Case management services require the treating doctor to submit documentation that identifies any HCP that contributes to the case management activity.” Review of the submitted documentation finds the following;
  - a. Case management note dated January 19, 2012 states, “General Purpose: Care Coordination” “Specific Purpose: Coordinating Care” “Outcome: The patient will continue medication management per Dr. Stephenson; The patient will move forward with approved lumbar spine surgery; continue contested case hearing process for inclusion of her bladder and bowel incontinence as an extension of compensability of her injury; continue with individual psychotherapy and support with medical condition.”

Review of the submitted documentation finds nothing to support the treating physician participated in the case management service. The carrier’s denial is supported.

- 3. No documentation was found to support Rule 134.204(e)(4) was met. Therefore no additional payment can be recommended.

**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**

Signature	Medical Fee Dispute Resolution Officer	August 21, 2014 Date
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**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, effective May 31, 2012, 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 MDR 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.**