



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

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Texas Health dba Injury 1 of Dallas

Respondent Name

Old Republic Insurance Co

MFDR Tracking Number

M4-13-1458-01

Carrier's Austin Representative

Box Number 44

MFDR Date Received

February 11, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CPT code 90806 was preauthorized."

Amount in Dispute: \$140.59

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
September 5, 2012	90806	\$140.59	\$139.58

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 §134.600 sets out the guidelines for prospective and concurrent review of health care.
- 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 197 – Precertification/authorization/notification absent

Issues

- Did the respondent support their denial of disputed services?
- What is applicable fee guideline?
- Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied disputed services as, 197 – “Precertification/authorization/notification absent.” 28 Texas Administrative Code §134.600(p)(7) states, “Non-emergency health care requiring preauthorization includes:... ..all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or division exempted return-to-work rehabilitation program;” Review of the submitted documentation finds an authorization notice from GENEX, dated August 27, 2012 with Start Date of 12-Aug-2012 and End Date 20-Nov-2012. Authorized services are Individual psychotherapy 1x6 weeks. The carrier’s denial is not supported therefore these services will be calculated per applicable rules and fee guidelines.
2. 28 Texas Administrative Code §134.203(c)(1) states in pertinent part, “This section applies to professional medical services provided in the Texas workers’ compensation system,” Approximate fee calculations are (Workman’s Compensation Conversion Factor / Medicare Conversion Factor x Non-Facility Price) or $54.86/34.0376 \times \$86.60 = \139.58 .
3. The total allowable is \$139.58. Insurance carrier previously paid \$0.00. The remaining balance of \$139.58 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$139.58.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$139.58 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	Date
		<u>April 15, 2014</u>

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.