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
Nueva Vida Behavioral Health and Associates

Respondent Name
Insurance Co of the State of PA

MFDR Tracking Number
M4-13-1507-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
February 15, 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: "…it is the carrier's position that the bill was paid denied correctly. This appears to be a staff meeting. Rule 134.204 states case management activities are the responsibility of the treating doctor primarily, but a referral provider may participate and bill for these activities. This was not a referral provider. An interdisciplinary team may not include employees of the coordinating provider. The fact that the involved group all work at same location with treating doctor makes it not payable (Staff meetings are not separately reimbursable)."

Response Submitted by: AIG, P.O. Box 25794, Shawnee Mission, KS 66225

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the reimbursement guidelines for case management services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - This service/supply is not covered according to the state fee schedule guideline.
   - Our position remains the same if you disagree with our decision please contact the TWCC Medical Dispute Resolution.

Issues

1. Did the requestor submit required documentation as required by rule 134.204?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed services as, "This service/supply is not covered according to the state fee schedule guideline." 28 Texas Labor Code §134.204 (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 June 19, 2012 states, "General Purpose: Care Coordination," "Specific Purpose: Coordinating Care," "Outcome: coordinate referral to Dr. Horne for cognitive skill development, continue with counseling; hold on pain management."

    Review of the submitted documentation finds nothing to support the treating physician participated in the case management service either by report, or telephone. The Division requirements are not met.

2. The Division finds the requirements of Rule 134.204 have not been met. No 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 27, 2014 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, 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.