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
City of San Antonio

MFDR Tracking Number
M4-13-1844-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
March 19, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The date of service being denied for payment is 4/10/12. This date of service was performed within the authorized timeframe and was denied in error."

Amount in Dispute: $660.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider requested preauthorization for this service on April 10, 2012. The enclosed pre-authorization letter indicates the request was "non-authorized" on April 13, 2012. Therefore, the bill was correctly denied utilizing ANSI reduction code 39 stating: Services denied at the time authorization/pre-certification was requested."

Response Submitted by: Argus Services Corporation, 811 S. Central Expwy Suite 440 Richardson, TX 75080

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 10, 2012	90801	$660.00	$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 §134.600 sets out procedures for preauthorization, concurrent utilization review, and voluntary certification of health care.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 39 – Services denied at the time authorization/pre-certification was requested

Issues

1. Did the requestor support requirements of division rules were met?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed services as 39 – "Services denied at the time authorization/pre-certification was requested ." 28 Texas Labor Code §134.600 (8) states, "Preauthorization: a form of prospective utilization review by a payor or a payor's utilization review agent of health care services proposed to be provided to an injured employee." Review of the submitted documentation finds pre-authorization was requested for the disputed services but denied. Therefore, the carrier's denial is supported.
2. 28 Texas Administrative Code §134.600 (p) states, "Non-emergency health care requiring preauthorization includes:" (7), "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;" As the requestor did not have required authorization to provide the service in dispute, 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 , 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **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. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing 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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

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