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
Physician Mgmt Svcs dba Injury 1 Trtmt Ctr

Respondent Name
Indemnity Insurance Co of North

MFDR Tracking Number
M4-13-2666-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
June 17, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The insurance company denied the claims stating "The charge for this service exceeds the fee schedule allowance."

Amount in Dispute: $145.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This date of service is not covered on the Authorization Letter."

Response Submitted by: ESIS, 1851 E 1st St #200, Santa Ana, CA 92705

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 6, 2013	90806	$145.00	$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 the guidelines for prospective and concurrent review of health care.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197 – Precertification/authorization /notification absent
   - 247 – A payment or denial has already been recommended for this service
   - 309 – The charge for this procedure exceeds the fee schedule allowance.

Issues

1. Did the requestor support the services in dispute should be reimbursed?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the reconsideration of this claim as, 197 – "Precertification/authorization/notification absent." 28 Texas Labor Code §134.600 states in pertinent part, "(p) 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;…" review of the submitted documentation finds documentation from Bunch CareSolutions dated 04/05/2013 shows beginning date of authorization, 3/14/2013. The date of service in disputed is 11/6/2012. Therefore the carrier's denial is supported.
2. Requirements of Rule 134.600 were not met. No reimbursement 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

		June 17, 2014
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, 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.