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
TX Health dba Injury 1 - Dallas

Respondent Name
Hartford Insurance Company Of

MFDR Tracking Number
M4-13-3179-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
July 29, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CPT code 96116 was preauthorized, #9995750."

Amount in Dispute: $900.00

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
April 18, 2013	96116	$900.00	$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:
   - 39 – Services denied at the time authorization-certification was requested
   - 96 – Non-covered charge(s)
   - BL – This bill is a reconsideration of a previously reviewed bill.

Issues

1. Did the requestor comply with Division guidelines?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the services in dispute as, "39 – Services denied at the time authorization-certification was requested." 28 Texas Labor Code §134.600(p)(7) states in pertinent part, "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 letter from Coventry Workers' Comp Services dated April 11, 2013 with "0" Doctor Certified Quantity and "1" Non-Certified Quantity. Additional information states in second paragraph, "If you do not agree with this adverse determination, you have 30 days to request a standard reconsideration or an expedited reconsideration for imminent or ongoing service(s). The carrier's denial is supported.

2. Division guidelines not 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	April , 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.