



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

Texas Mutual

MFDR Tracking Number

M4-14-0609-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

October 22, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...we are the referring HCP and we are billing for case management service..."

Amount in Dispute: \$56.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute of 10/22/12 and 2/1/13. The requestor billed Texas Mutual for case management services on the date above. Texas Mutual reviewed the documentation and argues it does not meet the criteria for case management. For this reason no payment is due."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 22, 2012 February 11, 2013	99361	\$56.00	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.204 sets out the reimbursement guidelines for case management services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 744 – Does not meet the definition of case management per DWC rule 134.202 and/or 134.204.
 - 193 – Original payment decision is being maintained.

Issues

- 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, 744 – “Does not meet the definition of case management per DWC rule 134.202 and/or 134.204.” 28 Texas Labor Code §134.204(e)(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 10-22-2013 states, “General Purpose: Care Coordination” “Specific Purpose: Treatment plan” “Outcome: decision to hold on neuropsychological testing, support for work-injury and compensable, continue with individual and ombudsman support.”
- b. Case management note dated 2-11-2013 states, “General Purpose: Care Coordination” “Specific Purpose: Coordinating Care” “Outcome: moved to Imperial Ix in January. Having trouble contacting. Emailed, no response. Follow up with old physician Dr. (illegible).”

Review of the submitted documentation finds nothing to support that the treating physician participated in the case management service. The carrier’s position is supported.

2. Requirements of Division rules are not met. No payment can be recommended.

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	September , 2014 Date
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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.