TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
NUEVA VIDA BEHAVIORAL HEALTH ASSOCIATES

MFDR Tracking Number
M4-14-1064-01

MFDR Date Received
December 10, 2013

Respondent Name
LIBERTY INSURANCE CORP

Carrier's Austin Representative
Box Number 01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Nueva Vida Behavioral Health Associates performed a Diagnostic Interview on December 12, 2012, a Medication Management Interview on February 7, 2013, and individual psychotherapy on February 19, 2013 and March 6, 2013. The claim was denied based on 'Peer Review'. These dates of service were performed within the authorized timeframe and was denied in error."

Amount in Dispute: $1,105.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Provider is requesting reimbursement for date of service 12/12/2012 for code 90801. We have reprocessed to pay this date as the incorrect denial reason was used... Code 90791 was denied per recommendation of a peer review... Dates of service 2/19/13 and 3/6/13 are also denied as not preauthorized but please note that the code listed on the Table of Disputed Services and on the bill submitted with the dispute is 90834. This is not the code that the provider submitted for reimbursement..."

Response Submitted by: Liberty Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December12, 2012	90801	$660.00	$0.00
February 7, 2013	90791	$250.00	$0.00
February 19, 2013	90834	$135.00	$0.00
March 6, 2013	90834	$135.00	$0.00
TOTAL		$1,105.00	$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 §133.305 sets out the general Medical Dispute Resolution guidelines.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.308 sets out the procedure for Medical Dispute Resolution of Medical Necessity Disputes.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - X435 – Based on Peer Review, further treatment is not recommended.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that his claim was processed properly.
   - X598 – Claim has been re-evaluated based on additional documentation submitted no additional payment due.

Issues

1. Did the insurance carrier issue payment for CPT Code 90801 rendered on December 12, 2012?
2. Does the medical fee dispute referenced above contain information/documentation that indicates that there are **unresolved** issues of medical necessity for date of service February 7, 2013?
3. Did the requestor submit EOB's and CMS-1500's with the DWC060 request for CPT Code 90834 rendered on February 19, 2013 and March 6, 2013?
4. Is the requestor entitled to reimbursement?

Findings

1. The Requestor seeks reimbursement in the amount of $660.00, for CPT Code 90801 rendered on December 12, 2012. Review of the insurance carrier's documentation, supports that payment in the amount of $660.00 was issued to the Requestor for CPT Code 90801. As a result, the Requestor is not entitled to additional reimbursement for this disputed service.
2. Review of the submitted documentation finds that the medical fee dispute referenced above contains information/documentation that indicates that there are unresolved issues of medical necessity for date of service, February 7, 2013.

   The Division hereby notifies the requestor the appropriate process for resolution of an unresolved issue of medical necessity requires filing for an independent review to be conducted by an IRO (independent review organization) appropriately licensed by the Texas Department of Insurance, pursuant to 28 Texas Administrative Code §133.308. Information applicable to HEALTH CARE PROVIDERS on how to file for an IRO may be found at http://www.tdi.texas.gov/hmo/iro_requests.html under *Health Care Providers or their authorized representatives.*

   28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding…medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding…medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021."

   The medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of 28 Texas Administrative Code §133.307. 28 Texas Administrative Code §133.307 (c)(1)(B) provides that a request for medical fee dispute resolution may be filed not later than 60 days after a requestor has received the final decision, inclusive of all appeals.

   The division finds that due to the unresolved medical necessity issues, date of service, February 7, 2013 is not eligible for review until a final decision has been issued in accordance with 28 Texas Administrative Code §133.308.

   The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution. This dismissal is based upon a review of all the evidence presented by the parties in this dispute. Even though not all the evidence was discussed, it was considered. The Division finds that date of service, February 7, 2013 is not eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307.

3. The requestor seeks reimbursement for CPT code 90834 rendered on February 19, 2013 and March 6, 2013. Review of the CMS-1500's document that the requestor billed the insurance carrier for CPT code 90837 on February 19, 2013 and March 6, 2013.

   28 Texas Administrative Code §133.307(c)(2)(J), requires that the request shall include "a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier . . . and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250." Review of the submitted documentation finds that the requestor has not provided a copy of the medical bill(s) as originally submitted to the insurance carrier and/or as submitted to the insurance carrier for an appeal in accordance with §133.250. The Division concludes that the requestor has not met the requirements of §133.307(c) (2) (J).

   28 Texas Administrative Code §133.307(c)(2)(K), requires that the request shall include "a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider . . . or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB." Review of the submitted documentation finds that the request does not contain copies of EOBs for the disputed service provided on February 19, 2013 and March 6, 2013. Nor has the requestor provided evidence of insurance carrier receipt of the request for an EOB for CPT Code 90834 rendered on February 19, 2013 and March 6, 2013. The Division concludes that the requestor has not met the requirements of §133.307(c) (2) (K). As, a result, the requestor is not entitled to reimbursement for CPT Code 90834 rendered on February 19, 2013 and March 6, 2013.

4. Review of the submitted documentation finds that the Requestor is not entitled to additional reimbursement for the disputed services.

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	July 30, 2015 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.