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
Federal Insurance Co

MFDR Tracking Number
M4-14-1494-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
January 27, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…we are the referring HCP and we are billing for case management service/Please do not deny payment for this service as we are within the medical fee guidelines to bill for this service."

Amount in Dispute: $84.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: For each date of service, Requestor billed for a tem conference. This conference did not meet the requirements of DWC Rule 134.204(e)(1)(B)(2) which states that team conferences and telephone calls should be triggered by a documented change in the condition of the injured employee. There is not documented change in condition of the Claimant. As such, the documentation does not support the services billed.

Response submitted by: Downs Stanford PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 4, 2013 May 27, 2013 July 1, 2013	99361	$84.00	$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 §134.204 sets out the reimbursement guidelines for case management services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 4 – Required Modifier missing or inconsistent w/procedure
   - 125 – Denial/Reduction due to submission/billing error

- 150 – Payment adjusted/unsupported service level

Issues

1. 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, 150 – "Payment adjusted/unsupported service level." 28 Texas Labor Code §134.204 (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 February 4, 2013 states, General Purpose: "Care Coordination." Specific Purpose: "Coordinating Care." Outcome: "Dr. Clemmond (illegible) recommending continued physical therapy; mental health testing pre-auth in process."
    b. Case management note dated May 27, 2013 states, General Purpose: "Care Coordination, Return to Work." Specific Purpose: "Coordinating return to work"; Outcome: "shoulder surgery in process, support for surgery; establish vocational options post surgical."
    c. Case management note dated July 1, 2013 states, General Purpose:"Care Coordination", Specific Purpose: "Revising treatment plan"; Outcome: "consider individual; review assessments write report and submit for pre-auth."

    Review of the submitted documentation finds nothing to support the treating physician participated in the case management service either in person, by report, or telephone. The carrier's denial is supported.
2. No documentation was found to support Rule 134.204 was met. Therefore not 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

	Peggy Miller	September , 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.