



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

M4-14-2486-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

April 11, 2014

REQUESTOR'S POSITION SUMMARY

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

Amount in Dispute: \$128.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual reviewed the billing and attached documentation, and concluded it does not meet the criteria for the code at (e)(4)(A) of the Rule."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 7 – 8, 2014	99361, 96152	\$128.00	\$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 §133.305 sets out general provisions related to medical dispute resolution.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 197 – Precertification/authorization/notification absent
 - 219 – Based on extent of injury
 - 246 – The treatment/service has been determined to be unrelated to the extent of injury
 - 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. Upon review it was determined that this claim was processed properly

Issues

- 1. Did the requestor resolve the dispute for work related illness or injury?
- 2. Did the respondent support denial of services?
- 3. Is the requestor entitled to reimbursement?

Findings

- 1. The insurance carrier denied dates of service May 8, 2013 based on denial reason code “219 – Based on extent of injury,” during the medical bill review process. The dates of service referenced above contain unresolved issues of extent-of-injury for the same service(s) for which there is a medical fee dispute. The insurance carrier notified the requestor of such issues in its explanation of benefits (EOB) responses during the medical bill review process.

Dispute resolution sequence: 28 Texas Administrative Code §133.305(b) requires that extent-of-injury disputes be resolved prior to the submission of a medical fee dispute for the same services. 28 Texas Administrative Code §133.307(c) (2) (K) provides that a request for a medical fee dispute must contain a copy of each EOB related to the dispute.

Extent-of-injury dispute process: The Division hereby notifies the requestor that the appropriate process to resolve the issue(s) of extent of injury, including disputes or disagreements among the parties over whether the medical services in dispute were related to the compensable injury, may be found in Chapter 410 of the Texas Labor Code, and 28 Texas Administrative Code §141.1. As a result, dates of service May 8, 2013 were not considered in this review.

- 2. 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 May 7, 2013 states, “General Purpose: Care Coordination, Return to Work” “Specific Purpose: Coordinating Care, Coordinating return to work” “Outcome: continue with individual FCE to TDARS; establish vocational job searching.”

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

- 3. The Division finds requirements of Rule §134.204(e)(4) is not met. Therefore, no 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

October 30, 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.