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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Comfort in Counseling

Respondent Name
Indemnity Insurance Co of North

MFDR Tracking Number
M4-15-3355-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
June 10, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Reconsideration was sent on 5/1/2015 with copy of TDI rule 134.600 which indicates psychological services which do not require preauthorization and a letter stating that our initial evaluation did not require preauthorization."

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is Respondent's position that DWC Rule 134.600(p)(7) requires all psychological services to be preauthorized. The treatment in dispute in this matter was a psychological interview in which Requestor did not first obtain preauthorization. Therefore, reimbursement is not owed due to failure of the Requestor, and/or Claimant's treating doctor, to obtain preauthorization for the services."

Response Submitted by: Downs ♦ Stanford, P.C. 2001 Bryan Street, Suite 4000, Dallas, TX 75201

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 30, 2015	90791	$300.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 240 – Preauthorization not obtained

- 197 – Precertification/authorization/notification absent
- B13 – Re-evaluated no additional payment is recommended

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code197 – "Precertification/authorization/notification absent." 28 Texas Administrative Code §134.600 (p) states, "Non-emergency health care requiring preauthorization includes: (7) 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 information finds;

    a. Complete Evaluation / Diagnostic Evaluation dated January 30, 2015: "Test Results"

   The Division finds the carriers denial is supported as the medical record contains psychological test results which under Rule 134.600 (p) required prior authorization.

2. 28 Texas Administrative Code §134.600 (c) states, "The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care:

    (1) listed in subsection (p) or (q) of this section only when the following situations occur:

        (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions);

        (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care;

        (C) concurrent utilization review of any health care listed in subsection (q) of this section that was approved prior to providing the health care; or

        (D) when ordered by the commissioner;

   The Division finds the carrier is not liable for the services in dispute as none of the above apply.

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 16, 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, 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 MFDR 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.