



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

Respondent Name

Texas Mutual Insurance

MFDR Tracking Number

M4-16-0882-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

December 4, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Nueva Vida obtained preauthorization for 6 sessions of individual psychotherapy on 11/11/14 with certification # 10872615 was issued for the 6 sessions with a date range of 11/11/14 – 1/9/15."

Amount in Dispute: \$118.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor had preauthorization to provide the requested from 11/11/14 through 1/9/15. (Attachment) The requestor provided the disputed therapy on 1/14/15, outside the authorized time frame. No payment is due absent preauthorization."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 14, 2015	90837	\$118.00	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.600 sets out guidelines for prospective and concurrent review of health care.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 197 – Precertification/authorization/notification absent

- W3 – In accordance with TDI-DWC Rule 134.480, this bill has been identified as a request for reconsideration or appeal

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 code 197 – "Precertification/authorization/notification absent." 28 Texas Administrative Code §134.600(p) requires that, (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 that:

- Utilization Review Decision – "Per mutual agreement with Eric B at Nueva Vida, authorization is given for Individual Psychotherapy 6 Sessions over 8 Weeks, 90837, per Dr. Judson Somerville, to be done at Nueva Vida Behavioral Health Associates between 11/11/14-1/09/15.
- The date of service submitted on medical bill is January 14, 2015

The insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

2. 28 Texas Administrative Code §134.600 (c)(1)(B) 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:

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

Insufficient evidence was found to support that prior authorization was extended pas January 9, 2015. Therefore, the Division finds the carrier is not liable for the service in dispute.

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

February , 2016
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.