TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Nueva Vida Behavioral Health

Respondent Name
Old Republic Insurance Co

MFDR Tracking Number
M4-23-2564-01

Carrier's Austin Representative
Box Number 44

DWC Date Received
June 6, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 26, 2022	96158	$125.00	$0.00
September 26, 2022	96159	$90.00	$0.00
September 29, 2022	96158	$125.00	$0.00
September 29, 2022	96159	$90.00	$0.00
	Total	$430.00	$0.00

Requestor's Position

The requestor did not submit a position statement but did submit a copy of their reconsideration that states, "Pursuant to the Texas Department of Worker's Compensation Medical Fee Guidelines subchapter C §134.204 Medical Fee Guideline for Worker's Compensation Specific Services (1)(e), we are the health care provider and we are billing for behavioral intervention services. Please do not deny payment for this service as we are the within the medical fee guidelines to bill for this service."

Amount in Dispute: $430.00

Respondent's Position

"Our supplemental response for the above referenced medical fee dispute resolution is as

follows: the bills in question were escalated and a review completed. Our bill audit company has determined no further payment is due. …Rationale: Carrier is not liable. Third party case has settled.

Response Submitted by: Gallagher Bassett

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.

2. Texas Labor Code §417.002, outlines the process for recovery in third-party settlements.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- 109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor
- 215 – Based on subrogation of a third party settlement
- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly

Issues

1. Is Insurance Carrier's reason for denial supported?

Findings

1. The requestor is seeking reimbursement of professional medical services rendered in September of 2022. The insurance carrier states in their position statement, "Carrier not liable. Third party case has settled."

   Texas Labor Code §417.002(a-c), RECOVERY IN THIRD-PARTY ACTION states,

   (a) The net amount recovered by a claimant in a third-party action shall be used to reimburse the insurance carrier for benefits, including medical benefits, that have been paid for the compensable injury.

   (b) Any amount recovered that exceeds the amount of the reimbursement required under Subsection (a) shall be treated as an advance against future benefits, including medical

benefits, that the claimant is entitled to receive under this subtitle.

(c) If the advance under Subsection (b) is adequate to cover all future benefits, the insurance carrier is not required to resume the payment of benefits. If the advance is insufficient, the insurance carrier shall resume the payment of benefits when the advance is exhausted.

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The Division reviewed the submitted documentation and finds:

- Insufficient documentation was submitted to refute the carrier's position that the services in dispute are subject to payment from a third-party settlement; and
- No documentation was found to support the fact that the net amount recovered in the settlement was exhausted, and that the insurance carrier was required to pay benefits.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requestor has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		July 13, 2023
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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option three or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1 (d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción tres o correo electronico CompConnection@tdi.texas.gov.