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
TEXAS HEALTH LLC

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-09-7316-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
MARCH 27, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Preauthorization is not required per rule 134.600."

Requestor's Supplemental Position Summary: "…please withdraw DOS 05/05/08 from that MDR and only leave DOS 04/17/08."

Amount in Dispute: $195.71

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The service billed exceeds the treatment/services indicated in Rule 137.100 (Treatment Guidelines) effective 5/1/07 and required preauthorization in accordance with Rule 134.600."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 17, 2008	CPT Code 90801(X5) Psychiatric Diagnostic Interview Examination	$195.71	$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 §134.203, titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.600, requires preauthorization for specific treatments and services The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 930-Pre-authorization required, reimbursement denied.
   - CAC-197-Payment adjusted for absence of precertificantion/authorization/notification, this change effective 4/1/2008; precertification/authorization/notification absent.
   - CAC-W4-No additional reimbursement allowed after review of appeal/reconsideration.

- 891-The insurance company is reducing or denying payment after reconsideration.

Issues

Does a preauthorization issue exist? Is the requestor entitled to reimbursement?

Findings

28 Texas Administrative Code §134.600(p)(7) 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."

The requestor states in the position summary that "Preauthorization is not required per rule 134.600."

On April 25, 2008, the requestor obtained preauthorization approval for "1X4 90806."

A review of the April 17, 2008 report indicates that this is a "repeat behavioral medicine consultation…The results of this re-assessment are based on the assumption that the patient provided accurate information…"

Based upon this report, this is a repeat interview; therefore, preauthorization is required per 28 Texas Administrative Code §134.600(p)(7). The requestor did not submit any documentation that preauthorization was obtained for the disputed service, code 90801. As a result, reimbursement is not 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	05/16/2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing 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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.