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

Respondent Name
AMERISURE MUTUAL INSURANCE CO

MFDR Tracking Number
M4-12-1239-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
DECEMBER 21, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Rule 134.600 DOES NOT state that claims can be denied as not medically necessary based on an opinion or NOT understanding the relation of the medically necessary treatment to the compensable injury of a medical evaluator whom may or may not have had all of the patient's medical records for review at the time he/she conducted the peer review nor does it state anywhere that just because the payer deems the services were not medically necessary they can deny payment on these services."

Amount in Dispute: $610.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary dated January 9, 2012: "Attached are copies of 2 Peer Reviews from Dr. John Gregory dated 4.11.10 and 12.13.10. His findings in both reports remains the same. Based on his review of the medical records, he is of the opinion that claimant is no longer in need of further treatment following found MMI as well as the extensive treatment received that 'has not been reasonable per ODG criteria.' He further states there is no need for further physical therapy, DME, medication, or psychological evaluation."

Respondent's Supplemental Position Summary dated January 13, 2012: Please accept this as a supplemental response to the information we have already provided you. After reviewing this information, it appears that we may have not provided all of the medical bills, and that some of the date-stamps may have been cut off. I am providing you copies of the original medical bills, the recon medical bills, copies of the original EOBs, and copies of the reconsideration EOBs."

Responses Submitted by: Amerisure Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 13, 2011	CPT Code 99361 Case Management Services	$28.00	$0.00
	CPT Code 90801 (X3) Psychiatric Diagnostic Interview Examination	$582.00	$0.00
TOTAL		$610.00	$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 forth general provisions regarding dispute of medical bills.
3. 28 Texas Administrative Code §133.308 sets out the procedures for requesting review by an Independent Review Organization (IRO).
4.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 216-Based on the findings of a review organization. Denial per peer review.
   - Care coordination for individual psych is unnecessary. Psyc evaluation had no preauthorization.
   - 193-Original payment decision is being maintained. This claim was processed properly the first time.

Issues

1. Does a medical necessity issue exist?
2. Are the disputed services eligible for medical fee dispute resolution?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for the disputed services based upon a peer review performed by Dr. John Gregory on 4/11/10 and 12/13/10, that found that claimant has had extensive treatment that has not been reasonable per ODG criteria.
2. 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." 28 Texas Administrative Code §133.307(e)(3)(G) states "the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General)." The appropriate dispute process for unresolved issues of medical necessity is pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. Review of the submitted documentation finds that a medical necessity issue exists, therefore, the dispute was not filed in accordance with 28 Texas Administrative Code §133.305 and §133.307.
3. The requestor has failed to support that the disputed services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

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	07/03/2014 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.