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 and Address

NUEVA VIDA BEHAVORIAL HEALTH ASSOCIATES
5555 FREDERICKSBURG RD STE 102
SAN ANTONIO TX 78229

Respondent Name
Texas Mutual Insurance Co

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-12-2736-01

MFDR Date Received
April 24 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "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 referring HCP and we are billing for case management services"

Amount in Dispute: $28.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual maintains its position as communicated to the requestor through the Explanation of Benefits forms."

Response Submitted by: Texas Mutual Insurance Co

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 28, 2011	Professional Services	$28.00	$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 §134.202 sets out the guidelines for medical fees.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 744 – DOES NOT MEET THE DEFINITION OF CASE MANAGEMENT PER DWC RULE 134.202 AND/OR 134.204
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.

Issues

1. Did the requestor provide documentation to support applicable Division rules?
2. Did the respondent support the reason for denial?
3. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.202(3) states in pertinent part, "Case Management is the responsibility of the treating doctor. Team conferences and phone calls shall include coordination with an interdisciplinary team (members shall not be employees of the coordinating HCP and the coordination must be outside of an interdisciplinary program). Documentation shall include the name and specialty of each individual attending the team conference or engaged in a phone call. Team conferences and phone calls should be triggered by a documented change in the condition of the injured employee and performed for the purpose of coordination of medical treatment and/or return to work for the injured employee." Review of the "CASE MANAGEMENT NOTE" finds the following:
    a. Listed as Triggers are: "EMG referral was denied; individual psychotherapy approved. "

   There is nothing to document a change in condition as required by applicable rule. Therefore, the Division finds the requirements of 28 Texas Administrative Code §134.203(3) have not been met.

2. The carrier denied the disputed service as, "744 – DOES NOT MEET THE DEFINITION OF CASE MANAGEMENT PER DWC RULE 134.202 AND/OR 134.204." Review of the submitted documentation finds the carriers' denial is supported.

3. The review of the submitted documentation finds no additional reimbursement can be 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

		February 5, 2014
Signature	Medical Fee Dispute Resolution Officer	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.