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
INJURY-1 TREATMENT CENTER

Respondent Name
ASSOCIATION CASUALTY INSURANCE

MFDR Tracking Number
M4-12-3429-02

Carrier's Austin Representative
Box Number 53

MFDR Date Received
July 23, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim was denied stating 'unnecessary medical', please be aware that by denying payment to the healthcare provider, you are in violation of Rule 133.301 (a) Rules clearly convey that the carrier is liable for all reasonable and necessary medical costs when **preauthorization is obtained.** Further, a carrier **shall not deny reimbursement based on medical necessity for preauthorized healthcare.**"

Amount in Dispute: $271.22

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier is disputing extent of injury on this case, which ***has not been finally adjudicated at this time.*** Therefore, this dispute would not be subject to MDR."

Response Submitted by: Hoffman Kelley

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 7, 2011 and November 11, 2011	90806 x 2	$271.22	$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 §134.600 sets out the procedure for Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - O – Denial after reconsideration.
   - W9 – Unnecessary medical treatment based on peer review.

Issues

1. Did the insurance carrier submit documentation in the form of EOBs to support the issue of extent of injury raised in the position summary?
2. Did the requestor obtain preauthorization for the disputed charges?
3. Is the requestor entitled to reimbursement?

Findings

1. To determine whether such an extent-of-injury or related dispute existed at the time any particular medical fee dispute was filed with the Division and whether it was related to the same service, the applicable former version of 28 Tex. Admin. Code § 133.240(e), (e)(1), (2)(C), and (g) addressed actions that the insurance carrier was required to take, during the medical billing process, when the insurance carrier determined that the medical service was not related to the compensable injury: 31 Tex Peg 3544, 3558 (April 28, 2006). Those provisions, in pertinent parts, specified:

   Former 133.240(e), (e) (1), (2) (C), and (g): The insurance carrier shall send the explanation of benefits in the form and manner prescribed by the Division.... The explanation of benefits shall be sent to: (1) the health care provider when the insurance carrier makes payment or denies payment on a medical bill; and (2) the injured employee when payment is denied because the health care was: ... (C) unrelated to the compensable injury, in accordance with §124.2 of this title ,... (g) An insurance carrier shall have filed, or shall concurrently file, the applicable notice required by Labor Code §409.021, and §124.2 and 124.3 of this title ... if the insurance carrier reduces or denies payment for health care provided based solely on the insurance carrier's belief that:. . (3) the condition for which the health care was provided was not related to the compensable injury.

   The insurance carrier did not submit documentation (EOB's) to support the extent if injury issue raised in the position summary. As a result, the extent of injury issue is not supported and the disputed charges are reviewed pursuant to applicable rules and guidelines.

2. Per 28 Texas Administrative Code §134.600 "(p) 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."

   Review of the preauthorization letter issued by Forte dated September 8, 2011 indicates that preauthorization was obtained for outpatient IPT (Interpersonal Psychotherapy) x 6 sessions as related to the left foot. Forte also stated "The requesting provider has represented to Forte that the authorized services will be initiated within the next 30 days and this representation was a material factor in our determination that the services were medically necessary."

   The requestor disputes non-payment of CPT code 90806 rendered on November 7, 2011 and November 11, 2011. The Division finds that the disputed dates of service exceed the preauthorized timeframe approved by Forte. As a result, reimbursement for CPT code 90806 cannot be recommended.

3. Review of the submitted documentation finds that the requestor is not entitled to reimbursement for CPT code 90806 rendered on November 7, 2011 and November 11, 2011.

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

		September 5, 2014
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 in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *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 MDR 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.