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 and Associates

Respondent Name
North East Independent School

MFDR Tracking Number
M4-14-2320-01

Carrier's Austin Representative
Box Number 55

MFDR Date Received
March 28, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…we are the referring HCP and we are billing for case management services. Please do not deny payment for this service as we are within the medical fee guidelines to bill for this service."

Amount in Dispute: $128.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier maintains position that documentation does not support the level of care for CPT 99361 as defined by DWC MFG/DWC Rules 134.202(e)(3) and 134.204(d) and reimbursement is not warranted. Carrier is being billed for a case management meeting on 05/07/13 between the treating doctor and Nueva Vida Counseling staff that documented the need for care that had already been ordered and completed by the treating doctor and referral doctor two months prior on 03/14/13, Nueva Vida staff did not contribute to the case management as the outcome/treatment plan had already been developed and implemented by the treating doctor; therefore, Nueva Vida is not eligible for reimbursement of service in dispute."

Response Submitted by: North East Independent School District

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 7, 2013	99361	$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 §134.204 sets out the guidelines for Workers' Compensation Specific Services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 150 – Payer deems the information submitted does not support this level of service
   - 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly

Issues

1. Did the respondent support denial of services?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed services as, 150 – "Payer deems the information submitted does not support this level of service." 28 Texas Labor Code §134.204(e) Case Management Responsibilities by the Treating Doctor is as follows: (2) Team conferences and telephone 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 submitted documentation finds the following;
    a. Case management note dated May 6, 2013 states, "Triggers: tertiary care consideration, vocational planning needed, physical functioning deficits, affective functioning deficits."

    Review of the submitted documentation finds no documented change in the condition of the injured employee. The carrier's position is supported.

2. The Division finds requirements of Rule §134.204(e)(4) is not met. Therefore, no payment 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

	Peggy Miller	December , 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.