



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Nueva Vida Behavioral Health

**Respondent Name**

Liberty Mutual Insurance Co

**MFDR Tracking Number**

M4-25-0292-01

**Carrier's Austin Representative**

Box Number 60

**DWC Date Received**

October 1, 2024

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 13, 2024	96158	\$150.00	\$0.00
May 13, 2024	96159	\$100.00	\$0.00
<b>Total</b>		<b>\$250.00</b>	<b>\$0.00</b>

### Requestor's Position

"Pursuant to the Texas Department of Workers' Compensation Medical Fee Guidelines subchapter C §134.204 Medical Fee Guideline for Worker's Compensation Specific Services (1) (e) we are the health care provider and we are billing for behavioral intervention services."

**Amount in Dispute:** \$250.00

### Respondent's Position

"The bill has been reviewed and denial stands per PLN11 filed... The compensable injury is limited to (redacted). All other injuries, conditions, diagnosis, and symptoms are denied as not being the direct result of, or naturally resulting from the compensable accident."

**Response submitted by** Liberty Mutual

## Findings and Decision

### Authority

This medical fee dispute is decided according to [Texas Labor Code §413.031](#) and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

### Statutes and Rules

1. [28 Texas Administrative Code \(TAC\) §133.307](#) sets out the procedures for resolving medical fee disputes.
2. [28 TAC §134.600](#) sets out the requirements of prior authorization.

### Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- 5917 – Pre-authorization was required, but not requested for this service per DWC Rule 134.600.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

### Issues

1. Is the insurance carrier's position statement supported?
2. Is the insurance carrier's denial supported?

### Findings

1. Review of the insurance carrier's response finds new denial reasons or defenses raised that were not presented to the requestor before the filing of the request for medical fee dispute resolution.

A review of the submitted information finds insufficient documentation to support that an EOB was presented to the health care provider, giving notice of the extent of injury, denial reasons or defenses prior to the submission of the medical fee dispute resolution request

Rule §133.307(d)(2)(F) requires that: The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.

2. The insurance carrier denied the disputed service for lack of prior authorization. DWC Rule 28 TAC §134.600(p)(7) states in pertinent part, "Non-emergency health care requiring preauthorization includes all psychological testing and psychotherapy..."

Review of the submitted documentation found insufficient evidence to support the required prior authorization was obtained. The insurance carrier's denial is supported. No payment is recommended.

**Conclusion**

For the reasons stated above, the DWC finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

**Order**

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to \$0.00 reimbursement for the disputed services.

**Authorized Signature**

_____	_____	<u>October 31, 2024</u>
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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at [www.tdi.texas.gov/forms/form20numeric.html](http://www.tdi.texas.gov/forms/form20numeric.html). DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in [28 TAC §141.1\(d\)](#).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).