TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Nueva Vida Behavioral Health

Respondent Name
National Casualty Co

Carrier's Austin Representative
Box Number 6

MFDR Tracking Number M4-25-1748-01

DWC Date Received
April 2, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 16, 2024	99213-25	$200.00	$0.00

Requestor's Position

"The consultation for psychotropic medication does not require preauthorization."

Amount in Dispute: $200.00

Respondents' Position

"The carrier denied the medical bills for several reasons including lack of preauthorization. It is the carrier's position that the services provided required preauthorization on the basis that the services were beyond the ODG."

Response Submitted by: Flahive, Ogden & Latson

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §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 §133.240 sets out the requirements of medical bill processing by insurance carriers
3. The Texas Insurance Code (TIC) §19.2009 sets out the requirements of utilization review prior to adverse medical necessity.
4. 28 TAC §134.600 sets out the requirements of prior authorization.
5. 28 TAC §134.203 sets out the billing and coding requirements for professional medical services.

Denial Reasons

The insurance carrier reduced the payment for the disputed services with the following claim adjustment codes:

- W3 – Bill is a reconsideration or appeal
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on the re-evaluation we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration
- 5089 – Adj – Preauthorization required but not requested
- 252 – The recommended allowance is based on the value for services performed by a licensed non-physician practitioner
- P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

1. Did the respondent raise a new issue?
2. Did the carrier follow the appropriate administrative process to address the assertions made in its response to medical fee dispute?
3. Is the insurance carrier's denial for lack of prior authorization supported?
4. What rule is applicable to reimbursement?

Findings

1. The respondent states in their position statement, "We are attaching a PLN 11 dated September 4, 2024 that raised an extent of injury dispute concerning psychological conditions. It is the carrier's position that the treatment was based upon…."

   DWC §133.307(d)(2)(F) states in pertinent part, "The responses 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. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MFDR will be dismissed in accordance with subsection (f)(3)(B) or (C) of this section."

   A review of the submitted EOB does not support the denial based upon extent. As a result, due to the insufficient documentation the DWC will proceed with the audit of the disputed charges.

2. The respondent also states in their position statement, "It is the carrier's position that the services provided required preauthorization on the basis that the services were beyond the ODG."

   DWC Rule 28 Texas Administrative Code §133.240 (q) states, in relevant part, "When denying payment due to an adverse determination under this section, the insurance carrier shall comply with the requirements of §19.2009 of this title ... Additionally, in any instance where the insurance carrier is questioning the medical necessity or appropriateness of the health care services, the insurance carrier shall comply with the requirements of §19.2010 of this title …, including the requirement that prior to issuance of an adverse determination the insurance carrier shall afford the health care provider a reasonable opportunity to discuss the billed health care with a doctor ..."

   Submitted documentation does not support that the insurance carrier followed the appropriate procedures for a retrospective review denial of the disputed services outlined in §19.2003 (b)(31) or §133.240 (q). Therefore, the insurance carrier did not appropriately raise medical necessity for this dispute and this denial reason will not be considered in this review

3. The requestor is seeking reimbursement of code 99213 – "Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded." The insurance carrier denied the original bill and reconsideration as preauthorization required but not requested.

   DWC Rule 134.600 (p)(7)(10)(12)(14) states in pertinent parts, "Non-emergency health care requiring preauthorization includes: all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized return-to-work rehabilitation program… chronic pain management/interdisciplinary pain rehabilitation…

treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier… any treatment for an injury or diagnosis that is not accepted by the insurance carrier under Labor Code §408.0042 and §126.14 of this title (relating to Treating Doctor Examination to Define the Compensable Injury)."

The evaluation and management code submitted is not within the categories listed above. The insurance carrier's denial for lack of prior authorization is not supported.

4. The requestor submitted a medical bill with Code 99213 used to describe services rendered. Additionally, the place of service used in the submission of the medical bill indicates the services were rendered via telemedicine. DWC Rule 134.203 (b)(1) states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits…"

   The requirements for correct coding are.

   - Medically appropriate history and/or examination
   - Low level of medical decision. Medical decision making includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option. To qualify for a particular level of medical decision making, two of the three elements for a level of medical decision making must be met or exceeded.
   - Number and complexity of the problems that are addressed at an encounter
   - The amount and/or complexity of data reviewed and analyzed
   - Risk of complications and/or morbidity or mortality of patient management

   Review of the submitted "Progress Note" dated August 16, 2024 indicates the telephone interview addressed issues related to "redacted." Insufficient evidence was found to support a medical history of the injured workers' condition. An order for medication was not made. A referral for therapy was made.

   The position statement from the requestor did not explain or support how the submitted documentation met the requirements of selected code in dispute. The requestor submitted insufficient evidence to support the level of service billed under CPT code 99213. No payment is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requestor has not established that reimbursement is due.

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

	Medical Fee Dispute Resolution Officer	April 24, 2025
Signature		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. 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 three or email 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 tres o correo electronico CompConnection@tdi.texas.gov.