MEDICAL CONTESTED CASE NO. 08072

DECISION AND ORDER

This case is decided pursuant to Chapter 410 of the Texas Workers' Compensation Act and Rules of the Division of Workers' Compensation adopted thereunder.

ISSUE

A contested case hearing was held on June 26, 2008 to decide the following disputed issue:

> Is (Provider) entitled to $433.24 plus interest under CPT Code 90806 for services performed on November 26, 2007, December 5, 2007, December 17, 2007 and December 27, 2007?

PARTIES PRESENT

Carrier appeared and was represented by TW, attorney. Provider appeared by telephone and was represented by KM, attorney. Claimant appeared by telephone and was advised that his attendance was not required.

BACKGROUND EVIDENCE

The parties stipulated that the Claimant sustained a compensable injury on _____. The Carrier pre-authorized six sessions of psychotherapy and the Claimant underwent these sessions from November 26, 2007 through December 27, 2007. The Carrier paid for two of these sessions and requested this hearing to dispute payment for the services provided on November 26, 2007, December 5, 2007, December 17, 2007 and December 27, 2007. The Carrier argued that the Provider billed under an improper IDC-9 code for the services provided under CPT Code 90806 for individual psychotherapy. The Provider billed pursuant to CPT Code 90806 using the ICD-9 codes of 722.1 (disc displacement of thoracic and lumbar spine), 724.4 (lumbosacral neuritis) and 724.8 (back symptoms). Dr. M testified that the psychotherapy was recommended in order to assess the Claimant's psycho-social component related to the compensable injury. Dr. M testified that the Claimant was treated for adjustment disorder due to chronic pain and other stressors related to the compensable physical injury. Dr. M testified that the Claimant was referred to their facility as a result of his spinal injury and that all psychotherapy was a direct result of the compensable injury. Dr. M testified that they are instructed to give the primary diagnoses, in this case the thoracic and lumbar spine injuries, when submitting their bills pursuant to the Medicare guidelines which refer to the ICD-9 codes and that any secondary codes, such as adjustment disorder, were not required. The Carrier argued that the Claimant was treated for a psychological condition not a physical condition and that the correct ICD-9 code should have been a diagnosis code for a psychological disorder. The Carrier argued that the Provider was being deceitful by attempting to get the bill for psychotherapy sessions paid at a higher rate than allowable under the Medicare guidelines by using the compensable injury code instead of diagnosis code for a psychological condition.

Pursuant to Rule 134.202, for coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding,

billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section. Medicare utilizes the ICD-9 codes. In this case, the Carrier pre-authorized the psychotherapy treatment for the lumbar and thoracic spine diagnoses (ICD-9 codes 722.0, 724.8 & 724.4) and the Provider billed under these diagnoses. The psychotherapy sessions were recommended for treatment of the compensable injury and the proper ICD-9 codes are the primary diagnoses for the thoracic and lumbar spine conditions. The greater weight of the evidence is not contrary to the findings of Medical Review and the Provider is entitled to $433.24 plus interest under CPT Code 90806 for services rendered on November 26, 2007, December 5, 2007, December 17, 2007 and December 27, 2007.

Even though all the evidence presented was not discussed, it was considered. The Findings of Fact and Conclusions of Law are based on all of the evidence presented.

FINDINGS OF FACT

1. The parties stipulated to the following facts:

   A. Venue is proper in the (City) Field Office of the Texas Department of Insurance, Division of Workers' Compensation.

   B. On _____, Claimant was the employee of the (Employer) when he sustained a compensable injury.

   C. On May 14, 2008, the Medical Fee Dispute Resolution Officer determined that the Provider was entitled to $433.24 for the services performed on November 26, 2007, December 5, 2007, December 17, 2007 and December 27, 2007.

2. Carrier delivered to Claimant and Provider a single document stating the true corporate name of Carrier, and the name and street address of Carrier's registered agent, which document was admitted into evidence as Hearing Officer's Exhibit Number 2.

3. The preponderance of the evidence is not contrary to the decision of Medical Review rendered on May 14, 2008 that Provider is entitled to reimbursement for $433.24 under CPT Code 90806 for services rendered on November 26, 2007, December 5, 2007, December 17, 2007 and December 27, 2007.

CONCLUSIONS OF LAW

1. The Texas Department of Insurance, Division of Workers' Compensation, has jurisdiction to hear this case.

2. Venue is proper in the (City) Field Office.

3. (Provider) is entitled to $433.24 plus interest under CPT Code 90806 for services performed on November 26, 2007, December 5, 2007, December 17, 2007 and December 27, 2007.

DECISION

(Provider) is entitled to $433.24 plus interest under CPT Code 90806 for a services performed on November 26, 2007, December 5, 2007, December 17, 2007 and December 27, 2007.

ORDER

Carrier is ordered to pay benefits in accordance with this decision, the Texas Workers' Compensation Act, and the Commissioner's Rules.

The true corporate name of the insurance carrier is the **(SELF-INSURED)** and the name and address of its registered agent for service of process is

CITY CLERK
(ADDRESS)
(CITY), TEXAS (ZIP CODE)

Signed this 26th day of June, 2008.

Carol A. Fougerat
Hearing Officer