



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

KILLEEN INJURY CLINIC, INC.

Respondent Name

OLD REPUBLIC INSURANCE CO

MFDR Tracking Number

M4-10-4961-01

Carrier's Austin Representative

Box Number 44

MFDR Date Received

JULY 29, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Payment has been denied per the EOB stating unnecessary medical treatment based on peer review. Preauthorization was obtained prior to this patient's appointments. Proof of authorization was submitted with the reconsideration requests."

Amount in Dispute: \$303.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on the additional documentation received from the provider regarding this dispute, this matter is in the process of being re-audited for payment."

Response Submitted By: Harris & Harris

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 1, 2010 February 11, 2010	CPT Code 90806	\$128.70 X 2 = \$257.40	\$257.40
February 5, 2010	CPT Code 90901	\$47.20	\$47.20
TOTAL		\$303.20	\$303.20

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

- 28 Texas Administrative Code §133.307, effective May 25, 2008 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.600, effective May 2, 2006 requires preauthorization for specific healthcare and services.
- 28 Texas Administrative Code §134.203, effective March 1, 2008, 33 Texas Register 364, sets the reimbursement guidelines for the disputed service.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - W9-Unnecessary medical treatment based on peer review.
 - W4-No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. Does a medical necessity issue exist in this dispute?
2. Is the requestor entitled to reimbursement for codes 90806 and 90901?

Findings

1. The respondent states in the position summary that “Based on the additional documentation received from the provider regarding this dispute, this matter is in the process of being re-audited for payment.” On June 2, 2014, the Division contacted the requestor’s representative, Judith, and verified that no payment had been received and services remained in dispute.

According to the explanation of benefits, the respondent denied reimbursement for the disputed services based upon reason code “W9.”

The requestor asserts that payment is due because “Preauthorization was obtained prior to this patient’s appointments. Proof of authorization was submitted with the reconsideration requests.” In support of their position, the requestor submitted the following preauthorization reports:

- December 7, 2009: authorization for code 90806 “Individual Psychotherapy [1 time per week for 6 weeks] 6 visits”.
- December 7, 2009: authorization for code 90901 “Biofeedback therapy [1 time per week for 6 weeks] 6 visits”.

Per 28 Texas Administrative Code §134.600(I), “The carrier shall not withdraw a preauthorization or concurrent review approval once issued.” No documentation was submitted that the requestor exceeded the preauthorization approval; therefore, a medical necessity issue does not exist in this dispute. As a result, reimbursement is recommended per the Division’s fee guideline.

2. Per 28 Texas Administrative Code §134.203(c)(1)(2), “To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007.”

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2010 DWC conversion factor for this service is 54.32.

Review of Box 32 on the CMS-1500 the services were rendered in Killeen, Texas. The Medicare conversion factor for Killeen, Texas is 36.0791.

Using the above formula the Division finds the following:

CODE	Medicare Participating Amount	MAR	Amount Paid	Amount Due
90806	\$91.35	\$137.53, or lesser amount. The requestor is seeking	\$0.00	\$257.40

		\$128.70 X 2 = \$257.40		
90901	\$32.81	\$49.40, or lesser amount. The requestor is seeking \$47.20	\$0.00	\$47.20

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$303.20.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$303.20 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

06/05/2014
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing 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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.