TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXAS HEALTH DBA INJURY 1-DALLAS

Respondent Name
TEXAS SCHOOLS PROPERTY & CASUALTY

MFDR Tracking Number
M4-11-1314-01

Carrier's Austin Representative
Box Number 43

MFDR Date Received
December 20, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The patient was referred for an Initial Behavioral Medicine Consultation. The procedure was provided and the claim was denied per EOB payment denied/reduced for absence of precertification/authorization. CPT code 90801 does not require preauthorization per rule 134.600."

Amount in Dispute: $1,148.15

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "An EOB was issued on September 27, 2010 denying the bill as current treatment exceeded Official Disability Guidelines (ODG)... A request for reconsideration was received on October 12, 2010. The request for reconsideration was processed and denied again as treatment exceeds ODG."

Response Submitted by: JI Specialty Services, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 31, 2010	90801 x 5 units	$1,148.15	$233.32

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 §134.600 requires preauthorization for non-emergency health care.
3. 28 Texas Administrative Code §137.100 sets out the Treatment Guidelines.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197 – Payment denied/reduced for absence of precertification/authorization.
   - 5111 – The treatment falls outside the ODG Guideline. Based on Rule 134.600(p)(12) treatments and services that exceed or are not addressed by the commissioners adopted treatment guidelines or protocols and are not contained in an treatment plan preauthorized by the carrier require preauthorization.
   - 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

Issues

1. Did CPT Code 90801 require preauthorization?
2. Is CPT Code 90801 a timed unit code?
3. What is the Maximum Allowable Reimbursement (MAR) for CPT code 90801?
4. Is the requestor entitled to reimbursement?

Findings

1. This service was denied by the Respondent with reason code "197 – Payment denied/reduced for absence of precertification/authorization and 5111 – The treatment falls outside the ODG Guideline. Based on Rule 134.600(p)(12) treatments and services that exceed or are not addressed by the commissioners adopted treatment guidelines or protocols and are not contained in an treatment plan preauthorized by the carrier require preauthorization."

   28 Texas Administrative Code §134.600 (p)(12) states in pertinent part, "Non-emergency health care requiring preauthorization includes: (12) 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...."

   Pursuant to 28 Texas Administrative Code §137.100 (a) "Health care providers shall provide treatment in accordance with the current edition of the *Official Disability Guidelines - Treatment in Workers' Comp,* excluding the return to work pathways, (ODG), published by Work Loss Data Institute (Division treatment guidelines), unless the treatment(s) or service(s) require(s) preauthorization in accordance with §134.600 of this title (relating to Preauthorization, Concurrent Review and Voluntary Certification of Health Care) or §137.300 of this title (relating to Required Treatment Planning)." Health care provided in accordance with the Division treatment guidelines is presumed reasonable as specified in Labor Code §413.017, and is also presumed to be health care reasonably required as defined by Labor Code §401.011(22-a).

   Pursuant to 28 Texas Administrative Code §137.100 (f), "A health care provider that proposes treatments and services which exceed, or are not included, in the treatment guidelines may be required to obtain preauthorization in accordance with §134.600 of this title, or may be required to submit a treatment plan in accordance with §137.300 of this title."

   Review of the August 2010 ODG low back chapter under the psychology screening section finds that psychosocial assessment is "Recommended" The division concludes that the services were provided in accordance with 28 Texas Administrative Code §137.100. As a result, preauthorization is not required for CPT Code 90801. The requestor is therefore entitled to reimbursement pursuant to 28 Texas Administrative Code §134.203.

2. 28 Texas Administrative Code §134.203 states "states, "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   The Requestor's CMS 1500 billing form is reviewed which indicates CPT codes 90801 x 5 units. The description of CPT code 90801 is as follows: Psychiatric diagnostic interview examination including a history, mental status, and a disposition, and may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies. This is not a timed unit code; as a result, the requestor is entitled to one unit of CPT Code 90801. Reimbursement is calculated pursuant to 28 Texas Administrative Code §134.203 (c).

3. 28 Texas Administrative Code §134.203 states in pertinent part, "(c) 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 Requestor seeks $1148.15 for CPT Code 90801. The MAR reimbursement is $233.32, therefore, this amount is recommended.

4. Review of the submitted documentation finds that the requestor is entitled to reimbursement for CPT Code 90801 rendered on August 31, 2010 in the amount of $233.32.

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 $233.32.

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 $233.32 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		July 30, 2015
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.