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 and Address

NISAL CORP
PO BOX 24809
HOUSTON TX 77029

Respondent Name
NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative
Box Number 19

MFDR Tracking Number
M4-11-3269-01

MFDR Date Received
May 26, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to RULE 134.600 (p) 'Non-emergency health care requiring preauthorization includes:... (7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or Division exempted return-to-work rehabilitation program.' Therefore, an initial psychological interview (Initial Mental Health Evaluation) does not require pre-authorization. Please be advised that this patient was in a pre-authorized or Division exempted return-to-work rehabilitation program, therefore preauthorization for the repeat interview was not required."

Amount in Dispute: $275.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The medical bill(s) made the basis of this Medical Fee Dispute have been sent back [sic] the bill audit vendor for an additional review along with the information provided by the Requestor. I will advise of the outcome of the review once it is available to me."

Response Submitted by: Pappas & Suchma, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 22, 2010	96102	$75.00	$0.00
December 6, 2010	90806	$200.00	$0.00
TOTAL		$275.00	$0.00

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 a medical fee dispute.
2. 28 Texas Administrative Code §134.600 sets out the Preauthorization, Concurrent Review, and Voluntary Certification of Health Care.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 19 – (197) Precertification/authorization/notification absent
   - BL – To avoid duplicate bill denial, for all recon/adjustments/additional pymnt requests, submit a copy of this EOR or clear notation that rec...

Issues

1. Did the respondent submit an outcome of the review as indicated in the position summary?
2. Did the requestor obtain preauthorization for the disputed CPT codes?
3. Is the requestor entitled to reimbursement?

Findings

1. Review of the insurance carriers position summary states in pertinent part, "...medical bill(s) made the basis of this Medical Fee Dispute have been sent back [sic] the bill audit vendor for an additional review..." The insurance carrier has not submitted a supplemental response to advise the Medical Fee Dispute Resolution of the outcome of the review. Therefore, the division will therefore proceed with the review and issue a findings and decision based on the information contained in the dispute at the time of the audit.
2. Per 28 Texas Administrative Code §134.600 "(p) Non-emergency health care requiring preauthorization includes: (7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or division exempted return-to-work rehabilitation program; (8) unless otherwise specified in this subsection, a repeat individual diagnostic study: (A) with a reimbursement rate of greater than $350 as established in the current Medical Fee Guideline..."

   The requestor seeks reimbursement for CPT code 96102 defined by the AMA CPT Code Book as "Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face."

   The requestor seeks reimbursement for CPT code 90806 defined by the AMA CPT Code Book as "Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient."
3. The requestor indicates that the patient was in a pre-authorized or Division exempted return-to-work rehabilitation program and therefore preauthorization for the repeat interview was not required. The requestor submitted insufficient documentation with the DWC060 to support that the services were part of either a pre-authorized or division exempted return-to-work rehabilitation program. As a result, preauthorization was required and not obtained for CPT codes 96012 and 90806 and therefore, reimbursement cannot be recommended for the disputed charges.

Conclusion

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

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 23, 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.