



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

PHYSICIAN MANAGEMENT SERVICES
DBS INJURY 1 TREATMENT CENTER

Respondent Name

HARTFORD INSURANCE COMPANY OF MIDWEST

MFDR Tracking Number

M4-13-0856-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

DECEMBER 4, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claims are incorrectly denied. The claims were denied stating not medically necessary, please note the treatment was preauthorized."

Amount in Dispute: \$4,110.04

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier asserts that services were not rendered to the compensable condition under the December 23, 2010 injury."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 26, 2012 April 24, 2012 April 30, 2012 May 7, 2012 May 21, 2012	CPT Code 90901(X12) Biofeedback	\$713.52/ea	\$2,140.56
March 26, 2012 April 30, 2012 May 21, 2012 June 27, 2012	CPT Code 90806 Individual Psychotherapy	\$135.61/ea	\$258.34
TOTAL		\$4,110.04	\$2,398.90

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 §141.1 provides for the process to resolve liability and relatedness issues.
3. 28 Texas Administrative Code §134.203 effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
4. 28 Texas Administrative Code §134.600, effective May 2, 2006, requires preauthorization for specific treatments and services.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 50-These are non covered services because this is not deemed a medical necessity by the payer.
 - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
 - W4-No additional reimbursement allowed after review of appeal/reconsideration.
 - SRS407-Services denied. Please contact the Sedgwick claims examiner regarding these charges.
 - SRS720-Request for reconsideration reviewed. No further payment recommended.
 - SRS44-Services provided appears to be unrelated to the injury.
 - 148-This procedure on this date was previously reviewed.
 - 18-Duplicate claim/service.
 - W1-Workers compensation jurisdictional fee schedule adjustment.
 - 214-Workers compensation claim adjudicated as non-compensable. This payer not liable for claim or service/treatment.

Issues

1. Did the medical fee dispute referenced above contain information/documentation that indicates that there are **unresolved** issues of Compensability, Extent of Injury and/or Liability (CEL)? Are the disputed services, CPT code 90901 rendered on April 30 and May 7, 2012 and code 90806 on June 27, 2012 eligible for review by Medical Fee Dispute Resolution?
2. Does a medical necessity issue exist?
3. Is the requestor entitled to reimbursement?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for CPT code 90901 rendered on April 30 and May 7, 2012 and code 90806 on June 27, 2012 based upon reason codes "SRS44" and/or "214".

Unresolved Compensability, Extent-of-Injury and/or Liability dispute: The medical fee dispute referenced above contains unresolved issues of liability and relatedness for the same service(s) for which there is a medical fee dispute. The insurance carrier notified the requestor of such issues in its explanation of benefits (EOB) response(s) during the medical billing process.

Dispute resolution sequence: 28 Texas Administrative Code §133.305(b) requires that liability and relatedness disputes be resolved prior to the submission of a medical fee dispute for the same services. 28 Texas Administrative Code §133.307(f) (3) (C) provides for dismissal of a medical fee dispute if the request for the medical fee dispute contains an unresolved liability dispute for the claim. 28 Texas Administrative Code §133.307(c) (2) (K) provides that a request for a medical fee dispute must contain a copy of each EOB related to the dispute.

Compensability, Extent-of-Injury and/or Liability dispute process: The Division hereby notifies the requestor that the appropriate process to resolve the issue(s) of liability and relatedness including disputes or disagreements among the parties over whether the medical services in dispute were related to the compensable injury, may be found in Chapter 410 of the Texas Labor Code, and 28 Texas Administrative Code §141.1.

Dismissal provisions: 28 Texas Administrative Code §133.307(f)(3) provides that a dismissal is not a final decision by the Texas Department of Insurance, Division of Workers' Compensation ("Division"). The medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of 28 Texas Administrative Code §133.307. 28 Texas Administrative Code §133.307(c)(1)(B) provides that a request for medical fee dispute resolution may be filed not later than 60 days after a requestor has received the final decision, inclusive of all appeals, on the liability dispute.

2. The respondent denied reimbursement for CPT code 90901 rendered on March 26, and April 24, 2012 and code 90806 rendered on March 26, April 30, and May, 21, 2012 based upon reason code "50."

28 Texas Administrative Code §134.600(p)(7) requires preauthorization for “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.”

On March 22, 2012, the requestor obtained preauthorization approval from Specialty Risk Services, LLC, for six (6) units of individual psychology and biofeedback therapy, and a neuropsychological consultation. A review of the submitted documentation finds no records to support that the requestor exceeded the preauthorized therapy.

28 Texas Administrative Code §134.600(c)(1)(B) states, “The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care.” Furthermore, 28 Texas Administrative Code §134.600(l) states, “The carrier shall not withdraw a preauthorization or concurrent review approval once issued.” Because preauthorization was obtained for the disputed services a medical necessity issue does not exist; therefore, the respondent’s denial based upon reason code “50” is not supported.

3. To determine reimbursement for CPT code 90901 rendered on March 26, and April 24, 2012 and code 90806 rendered on March 26, April 30, and May, 21, 2012 the Division refers to 28 Texas Administrative Code §134.203.

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 2012 DWC conversion factor for this service is 54.86.

The Medicare Conversion Factor is 34.0376

Review of Box 32 on the CMS-1500 the services were rendered in zip code 76705, which is located in Waco, Texas; therefore, the Medicare participating amount is based on locality “Rest of Texas”.

Using the above formula, the MAR is:

Code	Medicare Participating Amount	MAR	Insurance Carrier Paid	Amount Due
90806	\$80.14	\$129.17 X 2 dates = \$258.34	\$0.00	\$258.34
90901	\$36.89	\$59.46 X 12 = \$713.52 X 3 dates =	\$0.00	\$2,140.56

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 \$2,398.90.

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 \$2,398.90 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

10/09/2015
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.