



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

Respondent Name

Indemnity Insurance Co of North

MFDR Tracking Number

M4-13-1444

Carrier's Austin Representative

Box Number 15

MFDR Date Received

February 11, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CPT code 90806 was preauthorized, #1000950776 therefore it is deemed medically necessary. Per DWC Rule 133.301(a), the insurance carrier shall not retrospectively review the medical necessity of a medical bill for treatment(s) and/or service(s) for which the medical care provider has obtained preauthorization under Rule 134.600(h)."

Amount in Dispute: \$140.59

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Claimant has requested payment for psychotherapy sessions. Attached is a PLN-11 showing that no psychological condition has been accepted as part of this claim."

Response Submitted by: Smith & Carr, 9235 Katy Freeway, Suite 200, Houston, TX 77024

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 21, 2012	90806	\$140.59	\$132.94

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
- 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 50 – These are non-covered services because this is not deemed a medical necessity by the payer
 - W4 – No additional reimbursement allowed after review of appeal/reconsideration

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the applicable rule pertaining to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor states in their position, "CPT code 90806 was preauthorized, #1000950776 therefore it is deemed medically necessary. Review of the submitted documentation finds:

- Texas Outpatient Authorization Recommendation dated August 8, 2012
- Certified Treatment: Individual Psychotherapy 1 x wk x 6 wks

The insurance carrier denied disputed services with reason code 50 – "These are non-covered services because this is not deemed a medical necessity by the payer." Per Texas Administrative Code §133.240(b), "the insurance carrier shall not deny reimbursement based on medical necessity for health care preauthorized or voluntarily certified under Chapter 134 of this title (relating to Benefits--Guidelines for Medical Services, Charges, and Payments)." Review of the submitted information finds documentation to support that the disputed health care was preauthorized. The insurance carrier's denial reason does not meet the requirements of §133.240(b) and is not supported. As there are no unresolved issues of medical necessity, these services will be reviewed for medical fee dispute resolution.

2. 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." The maximum allowable reimbursement is calculated as follows;
 - a. Procedure code 90806, service date September 21, 2012. The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 1.86 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 1.87674. The practice expense (PE) RVU of 0.48 multiplied by the PE GPCI of 1.017 is 0.48816. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.834 is 0.05838. The sum of 2.42328 is multiplied by the Division conversion factor of \$54.86 for a MAR of \$132.94.
3. The total allowable reimbursement for the services in dispute is \$132.94. This amount less the amount previously paid by the insurance carrier of \$0.00 leaves an amount due to the requestor of \$132.94. This amount is recommended.

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 \$132.94.

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 \$132.94 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

September , 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, 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 MFDR 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.