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

NUEVA VIDA BEHAVIORAL HEALTH
SUITE 102
5555 FREDERICKSBURG ROAD
SAN ANTONIO TX 78229

Respondent Name
Alamo Community College District

Carrier's Austin Representative
Box Number 16

MFDR Tracking Number
M4-14-1434-01

MFDR Date Received
January 22, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Nueva Vida Behavioral Health Associates performed individual psychotherapy on February 4, 2013 for The claim was denied based the findings of the review organization [sic]". The date of service being denied for payment is 02/04/13. This date of service was performed within the authorized timeframe ad was denied in error [sic].) Prior Authorization was obtained for all the services we provided, which were medically necessary in aiding the patient recovery for the work related compensable injury (see attached preauthorization letter)."

Amount in Dispute: $135.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent would show that Requestor is not entitled to reimbursment for the services at issue, because such services do not represent reasonable and necessary medical treatment for the compensable injury. Specifically, the psychotherapy performed by Requestor does not appear to have been provided for the compensable injury."

Response Submitted by: Adami, Shuffield, Scheihing & Burns

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 4, 2013	90837	$135.00	$135.00

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 guidelines for Preauthorization, Concurrent Review, and Voluntary Certification of Health Care.

3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time.
   - QA – The amount adjusted is due to bundling or unbundling of services.
   - 216 – Based on the findings of a review organization.
   - PI – These are adjustments initiated by the payer, for such reasons as billing errors or services that are considered not reasonable or necessary. The amount adjusted is generally not the patients responsibility, unless the workers compensation state law allows the patient to be billed.

Issues

1. Did the insurance carrier support the denial reason indicated on the EOB?
2. Did the requestor bill pursuant to 28 Texas Administrative Code §134.203?
3. Is the requestor entitled to reimbursement?

Findings

1. 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."

   The insurance carrier denied the disputed CPT code with denial reason "216 – Based on the findings of a review organization."

   Review of a preauthorization letter dated December 4, 2012, issued by Sedgwick CMS preauthorized CPT code 90806-PSYTX OFF 45-50 MIN, Reference # KHEV, Certified Units 6, Start Date 11/29/12 and an End Date 2/4/2013. The insurance carrier preauthorized CPT code 90806 on December 4, 2012.

   The CPT code 90806 is 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." The CPT code 90806 was deleted by the AMA CPT on January 1, 2013.

   The requestor rendered the preauthorized service, as a result, the disputed charges are reviewed pursuant to 28 Texas Administrative Code §134.203(b).
2. Per 28 Texas Administrative Code §134.203 "(**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."

   Review of the submitted documentation finds that the requestor obtained preauthorization for CPT code 90806 on December 4, 2012. On January 1, 2013, the AMA CPT Code Book deleted CPT code 90806. The disputed service was rendered on February 4, 2013. The requestor billed the most current CPT code effective on the service date. The requestor billed CPT code 90837 defined by the AMA CPT Code Book as "Psychotherapy, 60 minutes with patient and/or family member."

   The requestor, billed and documented for the preauthorized psychotherapy services, as a result, the disputed charge is reviewed pursuant to 28 Texas Administrative Code §134.203 (c).
3. Per 28 Texas Administrative Code §134.203 "(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."

   Per 28 Texas Administrative Code §134.203 "(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title."

   The MAR reimbursement for CPT code 90837 is $188.15. The requestor seeks reimbursement in the amount of $135.00, therefore 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 $135.00.

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 $135.00 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	March 28, 2014 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).