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
TX HEALTH DBA INJURY 1 OF DALLAS

Respondent Name
AMERICAN ZURICH INSURANCE CO

MFDR Tracking Number
M4-14-3141-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JUNE 16, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Enclosed are copies of the EOBs (1st & 2nd denials), claims, and documentation. The patient was ordered an Initial Behavioral Medicine Assessment by his treating physician, Stephen Gist, MD. The service was provided and the claim was denied per EOB services denyied at the time authorization/pre-certification was requested. CPT code 90791 does not require preauthorization per rule 134.600."

Amount in Dispute: $1,052.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 6, 2013	CPT Code 90791 (X5) Psychiatric Diagnostic Evaluation	$1,052.30	$246.80

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 §134.203, titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.600, requires preauthorization for specific treatments and services.
4. 28 Texas Administrative Code §137.100, effective January 18, 2007, sets out the treatment guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 39-Services denied at the time authorization/pre-certification was requested.
6. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on June 24, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal

delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review

Issues

1. Does CPT code 90791 require preauthorization?
2. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied reimbursement for the disputed psychiatric evaluation, code 90791, based upon "39-Services denied at the time authorization/pre-certification was requested."

   The requestor states in the position summary that "CPT code 90791 does not require preauthorization per rule 134.600."

   28 Texas Administrative Code §134.600(p)(7) states "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 requestor noted that the disputed service was an "Initial Behavioral Medicine Assessment". Per 28 Texas Administrative Code §134.600(p)(7), an initial psychiatric evaluation does not require preauthorization.

   28 Texas Administrative Code §134.600(p)(12) requires preauthorization for "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 carrier."

   The requestor billed the disputed service for diagnosis code "847.2 – Lumbar sprains and strains". According to the Low Back Chapter of the Official Disability Guidelines (ODG), behavioral treatment is a recommended treatment for patients with chronic low back pain; therefore, the disputed initial psychiatric evaluation does not require preauthorization. The Division finds that reimbursement is recommended per Division rules and guidelines.

2. 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 2013 DWC conversion factor for this service 55.3.

   The Medicare Conversion Factor is 34.023.

   The Medicare participating amount is $151.84.

   Review of Box 32 on the CMS-1500 the services were rendered in zip code 75243, which is located in Dallas, Texas.

   Using the above formula, the Division finds the MAR is $246.80.

   A review of the submitted billing and medical records finds that the requestor billed for five units of code 90791. The report indicates that one hour was billed for reviewing records; two hours for the clinical interview; and two hours for preparing the report. Per the CPT code descriptor this is not a timed procedure code. Furthermore, the requestor is billing for time that was not actual face-to-face time with the claimant; therefore, the billing of five units is inappropriate.

The Division finds that based upon the code descriptor, the MAR is $246.80. The respondent paid $0.00. As a result, the requestor is entitled to reimbursement of $246.80.

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 $246.80.

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 $246.80 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	02/03/2015 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.