



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

NUEVA VIDA BEHAVIORAL HEALTH

Respondent Name

ASSOCIATION CASUALTY INSURANCE

MFDR Tracking Number

M4-15-0496-01

Carrier's Austin Representative

Box Number 53

MFDR Date Received

October 6, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Denying preauthorized health care services is an administrative violation in accordance with Rule 133.301(a)."

Amount in Dispute: \$854.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...the DWC Hearing Officer determined that the [date of injury] compensable injury does not extend to include degenerative changes at C5-C6, hearing loss, depression, mood anxiety, sleep disorders, vocational concerns and psychological stressors, conditions and diagnosis for which the provider treated the injured worker..."

Response Submitted by: Hoffman Kelley, L.L.P.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 1, 2014 through July 24, 2014	90837 x 7 and 99361	\$854.00	\$708.00

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

- 28 Texas Administrative Code §133.305 sets out the general instructions for Medical Dispute Resolution.
- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.600 sets out the Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care.
- 28 Texas Administrative Code §133.308 sets out the procedure for Medical Dispute Resolution of Medical Necessity Disputes.
- Former 28 Texas Administrative Code §133.240 sets out the procedure for Medical Payments and Denials.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - W9 – Unnecessary medical treatment based on peer review.
 - 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.

Issues

1. Did the insurance carrier raise the compensability, extent of injury and or liability issue during the bill review process?
2. Did the requestor submit documentation to support that the medical necessity issue(s) were resolved for CPT Code 99361 prior to the MFDR submission?
3. Did the requestor obtain preauthorization for CPT code 90837?
4. Is the requestor entitled to reimbursement?

Findings

1. To determine whether such an extent-of-injury or related dispute existed at the time any particular medical fee dispute was filed with the Division and whether it was related to the same service, the applicable former version of 28 Texas Administrative Code §133.240(e), (e)(1), (2)(C), and (g) addressed actions that the insurance carrier was required to take, during the medical billing process, when the insurance carrier determined that the medical service was not related to the compensable injury: 31 TexReg 3544, 3558 (April 28, 2006). Those provisions, in pertinent parts, specified:

Former 28 Texas Administrative Code §133.240(e), (e) (1), (2) (C), and (g): The insurance carrier shall send the explanation of benefits in the form and manner prescribed by the Division.... The explanation of benefits shall be sent to: (1) the health care provider when the insurance carrier makes payment or denies payment on a medical bill; and (2) the injured employee when payment is denied because the health care was... (C) unrelated to the compensable injury, in accordance with §124.2 of this title... (g) An insurance carrier shall have filed, or shall concurrently file, the applicable notice required by Labor Code §409.021, and §124.2 and §124.3 of this title... if the insurance carrier reduces or denies payment for health care provided based solely on the insurance carrier's belief that... (3) the condition for which the health care was provided was not related to the compensable injury.

Review of the submitted documentation does not support that the insurance carrier raised the extent of injury issue(s) during the bill review process, as a result, the Division will address the issue(s) raised during the bill review process.

2. The medical fee dispute referenced above contains information/documentation that indicates that there are **unresolved** issues of medical necessity for CPT Code 99361 for which there is a medical fee dispute. Review of the EOBs presented by the both the requestor and respondent indicate denial reason code "W9 – Unnecessary medical treatment based on peer review."

Resolution of a Medical Necessity Dispute: The Division hereby notifies the requestor the appropriate process for resolution of an unresolved issue of medical necessity requires filing for an independent review to be conducted by an IRO (independent review organization) appropriately licensed by the Texas Department of Insurance, pursuant to 28 Texas Administrative Code §133.308. Information applicable to HEALTH CARE PROVIDERS on how to file for an IRO may be found at http://www.tdi.texas.gov/hmo/iro_requests.html under **Health Care Providers or their authorized representatives.**

Notice of Dispute Sequence: 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding...medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding...medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021.

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.

The division finds that due to the unresolved medical necessity issues for CPT code 99361 rendered on July 15, 2014, is not eligible for review until a final decision has been issued in accordance with 28 Texas Administrative Code §133.308.

3. 28 Texas Administrative Code §134.600(p) states in pertinent part, “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 obtained preauthorization as indicated below. Review of the preauthorization letters submitted by the requestor document the following:

Authorization Number	Authorization Date	Authorized Timeframe	Start Date	End Date	MDR Number
1226660000	4/23/2014	6 sessions x 8 weeks	4/23/2014	6/30/2014	M4-15-0496
1236822001	7/3/2014	6 sessions x 8 weeks	7/2/2014	9/2/2014	M4-15-0496

The requestor submitted the following Medical Fee Disputes and referenced the Authorization numbers indicated above:

M4-15-0023-01					
Date of Service	Disputed CPT Code	Authorization Number	Authorization Start Date	Authorization End Date	Session Number
4/10/2014	90837	None	4/23/2014	6/30/2014	
5/1/2014	90837	1226660000	4/23/2014	6/30/2014	1
5/13/2014	99361	None			
6/4/2014	90885	None			
M4-15-0496-01					
Date of Service	Disputed CPT Code	Authorization Number	Authorization Start Date	Authorization End Date	Session Number
5/1/2014	90837	1226660000	4/23/2014	6/30/2014	Duplicate
5/8/2014	90837	1226660000	4/23/2014	6/30/2014	2
5/15/2014	90837	1226660000	4/23/2014	6/30/2014	3
5/22/2014	90837	1226660000	4/23/2014	6/30/2014	4
5/29/2014	90837	1226660000	4/23/2014	6/30/2014	5
6/3/2014	90837	1226660000	4/23/2014	6/30/2014	6
7/15/2014	99361	None			
7/24/2014	90837	1236822001	7/2/2014	9/2/2014	3
M4-15-0597-01					
Date of Service	Disputed CPT Code	Authorization Number	Authorization Start Date	Authorization End Date	Session Number
7/10/2014	90837	1236822001	7/2/2014	9/2/2014	1
7/17/2014	90837	1236822001	7/2/2014	9/2/2014	2

The division finds that CPT code 90837 rendered on May 1, 2014 will be addressed in Medical Fee Dispute M4-15-0023-01. The disputed dates of service rendered on May 8, 2014, May 15, 2014, May 22, 2014, May 29, 2014 and June 3, 2014 were preauthorized under Preauthorization Number 1226660000 and disputed date of service July 24, 2014 was preauthorized under Preauthorization Number 1236822001, as a result, the requestor is entitled to reimbursement for these dates of service.

28 Texas Administrative Code 134.600(c) states in pertinent part, “The insurance 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.”

The Division finds that the requestor obtained preauthorization for the psychotherapy rendered on May 8, 2014, May 15, 2014, May 22, 2014, May 29, 2014, June 3, 2014 and July 24, 2014. As a result, reimbursement will be determined per 28 Texas Administrative Code §134.203(c).

4. 28 Texas Administrative Code §134.203(c) states in pertinent part, "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 MAR reimbursement for CPT code 90837 is \$196.76 x 6 dates of service = a total of \$1,180.56, the requestor seeks \$118.00 x 6 date of service for CPT Code 90837 = a total MAR of \$708.00, 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 \$708.00.

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 \$708.00 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

May 1, 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.