



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

TX Health DBA Injury 1 - Dallas

Respondent Name

Sentry Casualty Co

MFDR Tracking Number

M4-16-1814-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

March 1, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The patient was approved for treatment.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: \$330.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Rows include dates March 30, 2015 and March 31, 2015 with corresponding service numbers and amounts.

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

- 1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care.
3. 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:
 - 197 – Precertification/authorization/notification absent
 - 193 – Original payment decision maintained
 - 216 – Based on the finding of a review organization

Issues

1. Is the carrier’s denial supported?
2. What is the applicable rule that pertain to reimbursement?
3. Is the requestor eligible for additional payment?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 197 – “Precertification/authorization/notification absent.” 28 Texas Administrative Code §134.600 (p)(7) states,

Non-emergency health care requiring preauthorization includes:

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 codes in dispute are **90837** – “Psychotherapy, 60 minutes with patient and/or family member”, and **96151** – “Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; re-assessment.”

Review of the submitted documentation finds document from “Coventry Workers’ Comp Services” dated February 25, 2015 that states: “Requested Service Description – Individual Psychotherapy 1xWkx4Wks 90827, Certified quantity – 4 Cognitive Therapy, Start Date 02/25/15, End Date 04/10/2015.”

Based on the above the carrier’s denial is not supported. The carrier also used denial code 216 – “Based on the findings of a review organization.” No evidence of said review was found within the submitted documentation. The carrier’s denial is not supported.

2. 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.

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. The maximum allowable reimbursement for the services in dispute is (date of service yearly conversion factor).

The services in dispute will be calculated as follows:

(DWC Conversion Factor/Medicare Conversion Factor) x Allowable = TX Fee MAR

90837 – (56.2/35.7547) x \$128.55 = \$202.06

96151 – (56.2/35.7547) x \$20.91 = \$32.87

Total \$234.93

The maximum allowable reimbursement is \$234.93. This amount is recommended.

3. The MAR for the services in dispute is \$234.93. The carrier previously paid \$0.00. The remaining balance of \$234.93 is due to the requestor.

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 \$234.93.

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 in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$234.93 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, 2016 Date
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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.