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 AND ASSOC

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-16-2084-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
MARCH 22, 2016

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: $700.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor is correct. Preauthorization is required for repeat psychological interviews. Further, there is no evidence from the requestor this diagnostic evaluation was part of a preauthorized or Division exempted return-to work rehabilitation program. No payment is due."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 16, 2015	CPT Code 90791 (X3) Psychiatric Diagnostic Evaluation	$700.00	$0.00

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 medical fee disputes.
2. 28 Texas Administrative Code §134.600, requires preauthorization for specific treatments and services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-151-Payment adjusted because the payer deems the information submitted does not support his many/frequency of services.
   - CAC-197-Precerfitican/authorization/notification absent.
   - 298-Only one is allowed per date of service.
   - 786-Denied for lack of preauthorization or preauthorization denial in accordance with the network contract.
   - CAC-W3, 350-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.

- CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 724-No additional payment after a reconsideration of services.

Issues

Did the disputed CPT code 90791 require preauthorization? Is the requestor entitled to reimbursement?

Findings

The insurance carrier denied reimbursement for the disputed psychiatric interview, code 90801, based upon "CAC-197-Precertification/Authorization/Notification absent," and "786-Denied for lack of preauthorization or preauthorization denial in accordance with the network contract."

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 respondent states in the position summary that "Preauthorization is required for repeat psychological interviews." In support of the position, the respondent submitted a copy of a bill for code 90791 rendered on September 11, 2014; therefore, the disputed service is a repeat interview and requires preauthorization.

Review of the submitted documentation finds that the requestor did not submit documentation to support that the claimant was in a Division exempt return-to-work program or that preauthorization was obtained for the disputed service. Therefore, preauthorization was required for CPT code 90791. As a result, the insurance carrier's EOB denial of "CAC-197" and "786" is supported and no reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	04/07/2016 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.