



# 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**

PHYSICIAN MANAGEMENT SERVICES

**Respondent Name**

INDEMNITY INSURANCE CO

**MFDR Tracking Number**

M4-16-2747-01

**Carrier's Austin Representative**

Box Number 15

**MFDR Date Received**

May 10, 2016

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "The carrier denied the bill stating not medically necessary. The treatment was preauthorized, notices attached. Per TWCC 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:** \$177.30

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** 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 May 17, 2016. 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.

#### SUMMARY OF FINDINGS

| Date(s) of Service | Disputed Service(s) | Amount In Dispute | Amount Due |
|--------------------|---------------------|-------------------|------------|
| September 24, 2015 | 90837               | \$177.30          | \$177.30   |

#### 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 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
3. 28 Texas Administrative Code §134.203 sets out the sets out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 203-Peer review has determined – payment for treatment has not been recommended due to the lack of medical necessity. Peer review has provided its findings to the provider in prior documentation
  - 216 – Based on the findings of a review organization

**Issues**

1. Does the medical fee dispute contain information/documentation to support that the disputed date of service contains issues of medical necessity?
2. Did the requestor submit documentation to support that CPT Code 90837 rendered on September 24, 2015 was preauthorized?
3. Is the requestor entitled to additional reimbursement?

**Findings**

1. The requestor seeks reimbursement for CPT code(s) 90837 rendered on September 24, 2015. The insurance carrier denied/reduced the disputed services with denial/reduction code(s) “203-Peer review has determined – payment for treatment has not been recommended due to the lack of medical necessity. Peer review has provided its findings to the provider in prior documentation” and “216 – Based on the findings of a review organization.”
2. 28 Texas Administrative Code §134.600 states in pertinent part, “(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.”

Review of the submitted preauthorization letter dated September 23, 2015 issued by Bunch CareSolutions (s) finds the following:

|                             |                                      |
|-----------------------------|--------------------------------------|
| Date Request Received       | 9/17/2015                            |
| Services Requested          | Psychological/Psychiatry (CBT 1 x 6) |
| Recommendation              | Certified                            |
| Date of Verbal Notification | 9/17/2015                            |
| Begin Service Date          | 9/22/15                              |
| End Service Date            | 1/22/16                              |
| Number of Visits/Services   | 1 x 6                                |
| Certification Number        | 28370669                             |

The requestor rendered CPT Code 90837 on September 24, 2015 within the preauthorized timeframes, as a result, the Division finds that the insurance carrier’s denial reason is not supported. The disputed service is therefore reviewed per applicable Division rules and fee guidelines.

3. 28 Texas Administrative Code §134.203 states in pertinent part, “(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...”

28 Texas Administrative Code §134.203 states in pertinent part, “(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 \$197.00. The Requestor seeks \$177.30, the lesser of is \$177.30, 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 \$177.30.

***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 \$177.30 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

|           |  |               |
|-----------|--|---------------|
|           |  | July 15, 2016 |
| Signature | Medical Fee Dispute Resolution Officer | 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, 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.**