



# 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](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

GABRIEL JASSO PH.D

**Respondent Name**

TEXAS MUTUAL INSURANCE CO

**MFDR Tracking Number**

M4-16-3113-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

JUNE 13, 2016

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "The carrier is denying the second unit for the psychiatric diagnostic evaluation. However, This code can be reported more than once for the patient when separate diagnostic evaluations are conducted. Please see report which outlines the reporting of 90791 for 2 units for this date of service is appropriate."

**Amount in Dispute:** \$193.57

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The requestor billed code 90791, 2 units, for a psychiatric diagnostic evaluation on 2/8/16. The requestor billed \$400.00. Texas Mutual paid the MAR of \$206.43. It is not clear what the requestor's basis is for payment of billed charges. In the DWC60 packet is a reference from CPT 2013 that 90791 may be billed more than once for the patient when separate evaluations are done with the patient and other informants. If that is the case there is no documentation in the DWC60 to support that anyone else, other than the claimant, was interviewed. Absent any explanation for payment of billed charges, Texas Mutual argues no additional payment is due."

**Response Submitted by:** Texas Mutual Insurance Co.

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 8, 2016	CPT Code 90791 (X2) Psychiatric Diagnostic Evaluation	\$193.57	\$6.54
	CPT Code 96101 Psychological Testing	\$0.00	\$0.00
TOTAL		\$193.57	\$6.54

#### 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, effective March 1, 2008, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - CAC-97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
  - 641-The medically unlikely edits (MUE) from CMS has been applied to this procedure code.
  - 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**

Does the documentation support billing CPT code 90791 (X2)? Is the requestor entitled to additional reimbursement?

## **Findings**

28 Texas Administrative Code §134.203(a)(5) states, "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

28 Texas Administrative Code §134.203 (b)(1) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

The requestor contends that reimbursement is due because "This code can be reported more than once for the patient when separate diagnostic evaluations are conducted. Please see report which outlines the reporting of 90791 for 2 units for this date of service is appropriate."

The respondent wrote, "In the DWC60 packet is a reference from CPT 2013 that 90791 may be billed more than once for the patient when separate evaluations are done with the patient and other informants. If that is the case there is no documentation in the DWC60 to support that anyone else, other than the claimant, was interviewed."

CPT code 90791 is defined as "Psychiatric diagnostic evaluation."

A review of the submitted billing and medical records finds that the requestor billed for two units of code 90791. The requestor included a copy of the 2013 CPT guideline that states, "In certain circumstances one or more other informants (family members, guardians, or significant others) may be seen in lieu of the patient. Codes 90791, 90792 may be reported more than once for the patient when separate diagnostic evaluations are conducted with the patient and other informants." A review of the submitted report does not support a separate diagnostic evaluation with anyone else other than the claimant to support billing the two units of code 90791. In addition, CPT code 90791 is not defined as a timed procedure. Based on the code descriptor and the submitted report, one unit is recommended for reimbursement.

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 2016 DWC conversion factor for this service 58.62

The Medicare Conversion Factor is 35.8043.

Review of Box 32 on the CMS-1500 the services were rendered in zip code 78230, which is located in San Antonio, Texas; therefore the Medicare carrier locality is "Rest of Texas".

The Medicare participating amount for code 90791 is \$130.08.

Using the above formula, the Division finds the MAR is \$212.97. The respondent paid \$206.43. As a result, additional reimbursement of \$6.54 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 \$6.54.

**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 \$6.54 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

07/13/2016  
\_\_\_\_\_  
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.**