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
GABRIEL JASSO PHD

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-17-1937-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
FEBRUARY 23, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134."

Amount in Dispute: $212.46

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual paid $212.46, the requestor's usual and customary charge per unit…It is not clear the requestor's basis for payment of two units. The 2016 CPT indicates 90791 may be billed more than once, when separate evaluations are done with the patient and other informants. There is no documentation in the DWC60 to support that anyone else, other than the claimant, was interviewed. Thus 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
October 17, 2016	CPT Code 90791 (X2) Psychiatric Diagnostic Evaluation	$212.46	$0.00
	CPT Code 96101 (X8) Psychological Testing	$0.00	$0.00
TOTAL		$212.46	$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 §134.203, 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 code:

- CAC-P12-Workers' compensation jurisdictional fee schedule adjustment.
- CAC-151-Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.
- 298-Only one is allowed per date of service.
- 790-This charge was reimbursed in accordance to the Texas medical fee guideline.
- 724-No additional payment after a reconsideration of services.
- CAC-193-Original payment decision is being maintained. This claim was processed properly the first time.
- CAC-W3, 350-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

Is the requestor entitled to additional reimbursement for CPT code 90791 (X2)?

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."

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. CPT code 90791 is not defined as a timed procedure; therefore, the service is considered per session and only one unit should be billed. No documentation was submitted to support a separate session with another individual was held except with claimant. 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 56.82.

The Medicare Conversion Factor is 35.8043.

Review of Box 32 on the CMS-1500 the services were rendered in zip code 77042, which is located in Houston, Texas; therefore the Medicare carrier locality is "Houston, Texas".

The Medicare participating amount for code 90791 is $134.47.

Using the above formula, the Division finds the MAR is $213.40 or less. The requestor billed $212.46 per unit The respondent paid $212.46. As a result, additional reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that 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

		03/13/2017
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, 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.