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
NUEVA VIDA BEHAVIORAL HEALTH

MFDR Tracking Number
M4-17-2984-01

MFDR Date Received
June 9, 2017

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative
Box Number 54

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This was [injured employee's] first psychological interview for this work related injury. Therefore, preauthorization was not required."

Amount in Dispute: $255.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Dr. Sean Connolly billed Texas Mutual for code 90791 on 2/11/16. Texas Mutual paid this billing. (Attachment) The requestor is mistaken in its assertion that its psychological interview was the first. Therefore, as the requestor rightly stated, preauthorization was required. Texas Mutual has no record the requestor either sought or was granted preauthorization for a repeat interview. Nor has the requestor provided any evidence it ought [sic] or was granted preauthorization for a repeat interview. No payment is due absent preauthorization."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
July 5, 2016	90791	$255.00	$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 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197 – precertification/authorization/notification absent
   - 930 – Pre-Authorization required, reimbursement denied

Issues

1. What is the definition of CPT Code 90791?
2. Did the requestor obtain preauthorization for the disputed services?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Code 90791 rendered on July 5, 2016. The insurance carrier denied CPT Code 90791 with claim adjustment reason code "197 – precertification/authorization/notification absent" and "930 – Pre-Authorization required, reimbursement denied."

   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."

2. 28 Texas Administrative Code §134.600 (p)(7) states in pertinent part, "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 documentation contained in the DWC060 request, does not support that the disputed service was the "initial" interview. In addition, the documentation provided does not support that the service in dispute was part of a preauthorized or division exempted return-to work rehabilitation program. Therefore, preauthorization was required for disputed CPT Code 90791.

   The Division finds the carrier's denial is supported. As a result, the requestor is not entitled to reimbursement for the disputed service.

3. Review of the submitted documentation finds that the requestor is not entitled to reimbursement for disputed CPT Code 90791 rendered on July 5, 2016. The Division finds that preauthorization was required and not obtained, as a result, the requestor is entitled to $0.00.

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	July 13, 2017 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.