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
ROBERT D'ANGELO, PHD

Respondent Name
METROPOLITAN TRANSIT AUTHORITY

MFDR Tracking Number
M4-18-4500-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JULY 27, 2018

REQUESTOR'S POSITION SUMMARY

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

Amount in Dispute: $224.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…The provider is seeking additional reimbursement on one of the CPT codes, 90791. The additional reimbursement being requested is $224.40. The provider billed for two units and was reimbursed for one unit. The provider is not entitled to additional reimbursement."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 16, 2018	CPT Code 90791 (X2)	$224.40	$0.00
	CPT Code 96101 (X8)	$0.00	$0.00
TOTAL		$224.40	$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 codes:
   - P12-Workers compensation jurisdictional fee schedule adjustment.

- 151-Payment adjusted because the payer deems the information submitted does not support this many services.
- W3-Additional reimbursement made on reconsideration.
- 193-Original payment decision is being maintained. This claim was processed properly the first time.
- W3/193-Per rule 134.804, W3 is to be used when a payment is made following a request for reconsideration. The service adjustment amount associated with this code may be zero. Original payment decision is being maintained.

Issues

1. What is the applicable fee guideline for professional services?
2. Does the documentation support billing CPT code 90791 (X2)? Is the requestor entitled to additional reimbursement?

Findings

1. The fee guidelines for disputed services are found in 28 Texas Administrative Code §134.203.
2. Based upon the submitted documentation the requestor billed $449.20 and was paid $224.56 for code 90791 (X2) based upon "151-Payment adjusted because the payer deems the information submitted does not support this many services, and P12-Workers compensation jurisdictional fee schedule adjustment."

   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."

   On the disputed date of service the requestor billed codes 90791 and 96101.

   The requestor contends that reimbursement is due because "The carrier has not paid this claim in accordance with TDI-DWC Rule 133 and 134."

   The respondent states in position summary that "Additional reimbursement would be inconsistent with the Medical Fee Guideline."

   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.

   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. The 2017 CPT manual indicates the code may be reported more than one per patient when a separate evaluation with an informant is performed.

   A review of the submitted documentation supports evaluation of the claimant; therefore, 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 2018 DWC conversion factor for this service 58.31.

The Medicare Conversion Factor is 35.9996.

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 $138.64.

Using the above formula, the Division finds the MAR is $224.56. The respondent paid $224.56. 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

Signature	Medical Fee Dispute Resolution Officer	08/22/2018 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.