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
NORTH TEXAS PAIN RECOVERY CENTER

Respondent Name
SERVICE LLOYDS INSURANCE CO

MFDR Tracking Number
M4-19-2768-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
JANUARY 18, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has denied payment of a psychological interview for the above mentioned claimant. The interview in question **is pursuant to the ODG and a required exam prior to utilization review of the Division Return to Work programming, 'Chronic Pain Management'**."

Amount in Dispute: $210.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We are upholding the original review. No preauthorization received and the preauth provided was per order 11/13/18 qty 80 for Chronic Pain Management…However, that was dated 11/20/18 and DOS is for 10/31/18.. .Therefore, we are unable to recommend any additional allowance."

Response Submitted by: AViDEL.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 31, 2018	CPT Code 90791(X1)	$210.00	$210.00

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, effective May 31, 2012, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600, effective March 30, 2014, requires preauthorization for specific treatments and services.
3. 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.
4. The services in dispute were reduced/denied by the respondent with the following claim adjustment reason codes:

- 95-Plan procedures not followed.
- U05-The billed service exceeds the UR amount authorized.
- W3-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 350-This bill has been identified as a request for reconsideration or appeal.

Issues

1. Did the disputed service require preauthorization?
2. Is the requestor entitled to reimbursement for CPT code 90791?

Findings

1. On the disputed date of service, the requestor billed $210.00 for CPT code 90791.Based upon the submitted explanation of benefits, the respondent denied payment of code 90791 based upon reason code "U05-The billed service exceeds the UR amount authorized."

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

   The division reviewed the following statute to determine if the respondent's reduction of payment is supported:

   - 28 Texas Administrative Code §134.600(p)(7) requires preauthorization for "all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized return-to-work rehabilitation program."

   - 28 Texas Administrative Code §134.600(p)(12) requires preauthorization for "treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier."

   - 28 Texas Administrative Code §137.100, Official Disability Guidelines, ODG, Pain Chapter, recommends psychological testing prior to a chronic pain management program.

   The division reviewed the submitted documentation and finds:

   - No documentation was submitted to support the October 31, 2018 psychiatric diagnostic evaluation was a repeat interview; therefore, the disputed psychiatric diagnostic evaluation did not require preauthorization per 28 Texas Administrative Code §134.600(p)(7).

   - The respondent wrote, "and the preauth provided was per order 11/13/18 qty 80 for Chronic Pain Management." The respondent did not submit a copy of the referenced preauthorization report to support position.

   - The requestor wrote, "The interview in question **is pursuant to the ODG and a required exam prior to utilization review of the Division Return to Work programming, 'Chronic Pain Management'."**

   - Per the division ODG, Pain Chapter, psychological testing is recommended prior to consideration of Chronic Pain Management program; therefore, the disputed psychiatric diagnostic evaluation did not require preauthorization per 28 Texas Administrative Code §134.600(p)(12).

   - The respondent's denial of payment based upon "U05" is not supported.

2. The fee guidelines for the disputed services is found at 28 Texas Administrative Code §134.203.

   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."

   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 76016 which is located in Arlington, Texas; therefore, the Medicare carrier locality is "Fort Worth, Texas".

The Medicare participating amount for code 90791 is $135.85.

Using the above formula, the Division finds the MAR is $223.61 or less. The requestor is seeking $210.00. The respondent paid $0.00. The division finds the requestor is due $210.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $210.00.

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 $210.00 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	2/13/2019 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.