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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TX HEALTH DBA INJURY 1 OF DALLAS

Respondent Name
CITY OF RICHARDSON

MFDR Tracking Number
M4-19-3364-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
March 5, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CPT code 90837 was approved… Please note a date extension was requested and was approved though 06/15/18."

Amount in Dispute: $432.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not submit a response for consideration in this review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
April 25, 2018 and May 11, 2018	Professional Medical Services	$432.50	$432.50

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and 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 sets out the fee guideline for professional medical services.
3. 28 Texas Administrative Code §134.600 sets out rules regarding preauthorization of health care.
4. The division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, receipt acknowledged March 13, 2019. Rule §133.307(d)(1) states, "The response will be deemed timely if received by the division … within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier has not responded. Accordingly, this decision is based on the information available at the time of review.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - T039 – Services were denied at the time authorization/recertification was requested.
   - P12 – The charge for the procedure exceeds the amount indicated in the fee schedule.
   - 97 – The payment for this service is bundled into payment of other services.
   - B13 – The provider has billed for the exact services on a previous bill.
   - P12 – The provider or a different provider has billed for the exact services on a previous bill where no allowance was originally recommended.

Issues

1. Are the insurance carrier's reasons for denial of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code:
   - T039 – Services were denied at the time authorization/recertification was requested.

   Rule §134.600(c) requires that "The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions); (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care."

   Rule §134.600(p)(7) states that non-emergency health care requiring preauthorization includes "all psychological testing and psychotherapy, repeat interviews, and biofeedback…" The disputed services involve CPT code 90837 — Psychotherapy (60 minutes); therefore, preauthorization was required for the non-emergency services.

   The provider submitted documentation of an authorization approval letter from Tristar supporting that CPT code 90837 was authorized for 1 visit per week for 4 weeks. The letter is dated 4/25/2018. The authorization period extends from March 20, 2018 to June 15, 2018. The disputed dates of service are April 25 and May 11, 2018. These dates fall within the authorized period.

   Based on the evidence presented to MFDR, the provider has supported the services were preauthorized. The insurance carrier's denial reasons are thus not supported and without merit. Consequently, the disputed services will be reviewed for payment in accordance with division fee guidelines.

2. This dispute regards medical services with reimbursement subject to the *Medical Fee Guideline for Professional Services*, 28 Texas Administrative Code §134.203, requiring the maximum allowable reimbursement (MAR) be determined by Medicare payment policies modified by DWC rules. The MAR is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the DWC annual conversion factor.

   Reimbursement is calculated as follows:

   - Procedure code 90837 (Psychotherapy, 60 minutes) has a Work RVU of 3 multiplied by the Work GPCI of 1.012 is 3.036. The practice expense RVU of 0.58 multiplied by the PE GPCI of 1.014 is 0.58812. The malpractice RVU of 0.11 multiplied by the malpractice GPCI of 0.768 is 0.08448. The sum is 3.7086 multiplied by the DWC conversion factor of $58.31 for a MAR of $216.25 per visit, for 2 visits totals
   - Procedure code 90889 (Report) has status indicator B, denoting a bundled code. Reimbursement is included with payment for other services to which this code is incident.

   The total allowable reimbursement for the disputed services is $432.50. The insurance carrier paid $0.00. The amount due is $432.50. This amount is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

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 $432.50.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $432.50, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

___________________________	Grayson Richardson	April 25, 2019
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 Rule §133.307.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.