**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**
TX HEALTH DBA INJURY 1 OF DALLAS

**Respondent Name**
NEW HAMPSHIRE INSURANCE CO

**MFDR Tracking Number**
M4-19-4533-01

**Carrier's Austin Representative**
Box Number 19

**MFDR Date Received**
JUNE 17, 2019

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Enclosed are copies of the EOB and claim, and documentation. The patient was approved for 2 hours of Psychiatric Diagnostic Interview and 2 hrs were provided but only 1 hour was paid. Please refer to the attached authorization letter for further review."

**Amount in Dispute:** $222.16

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** It has been determined that ESIS Med Bill Impact will stand on the original recommendation of $222.16. CPT code 90791 can only be billed once per day regardless of the time spent with he patient as this is not a timed service."

**Response Submitted by:** ESIS

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| November 14, 2018 | CPT Code 90791 (X2) | $222.16 | $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, effective May 31, 2012, 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.
   - 222-charge exceeds fee schedule allowance.
   - 267-Reimbursement of this procedure is limited to once per date of service.

- 119-Benefit maximum for this time period or occurrence has been reached.
- 151-Payment adjusted because the payer deems the information submitted does not support this many services.
- 193-Original payment decision is being maintained. This claim was processed properly the first time.
- CIQ378-This appeal is denied as we find our original review reflected the appropriate allowance for the service rendered. We find that no additional recommendation is warranted at this time.

**Issues**

Is the requestor entitled to additional reimbursement for CPT code 90791(X2) rendered on November 14, 2018?

**Findings**

1. Based upon the submitted documentation the requestor billed $500.00 and was paid $222.16 for code 90791 (X2) based upon the fee guideline.
2. The fee guidelines for disputed services is found in 28 Texas Administrative Code §134.203.
3. 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."
4. 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."
5. The requestor contends that reimbursement is due because "Enclosed are copies of the EOB and claim, and documentation. The patient was approved for 2 hours of Psychiatric Diagnostic Interview and 2 hrs were provided but only 1 hour was paid. Please refer to the attached authorization letter for further review."
6. The respondent states that "CPT code 90791 can only be billed once per day regardless of the time spent with he patient as this is not a timed service."
7. CPT code 90791 is defined as "Psychiatric diagnostic evaluation."
8. 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 2018 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.

10. 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 75243, which is located in

Dallas, Texas; therefore the Medicare carrier locality is “Dallas, Texas”.

The Medicare participating amount for code 90791 is $137.16.

Using the above formula, the Division finds the MAR is $222.16. The respondent paid $222.16. As a result, additional reimbursement is not recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is not 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**

| | | |
|---|---|---|
| | | 07/18/2019 |
| 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 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**.