



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

ACE AMERICAN INSURANCE CO

MFDR Tracking Number

M4-19-4542-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

JUNE 18, 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 & 3 hours of Psychological Testing. The services were provided and CPT code 90791 was paid below incorrectly and 2 hours were billed and not paid."

Amount in Dispute: \$333.24

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Corvel will maintain the requestor...is not entitled to additional reimbursement for date of service 11/15/18; CPT Code 90791 based on DWC adopted fee guideline, Medicare payment policies and correct coding initiative (CCI) edits in effect at the time services were provided."

Response Submitted by: Corvel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 15, 2018	CPT Code 90791 (X2)	\$333.24	\$111.08

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

- 28 Texas Administrative Code §133.307, effective May 31, 2012, sets out the procedures for resolving medical fee disputes.
- 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.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - P13-Payment reduced/denied based on state WC regs/policies.
 - RAI-Medical Unlikely Edit; DOS exceeds MUE value.
 - 18-Duplicate claim/service
 - R1-Duplicate billing.

Issues

Is the requestor entitled to additional reimbursement for CPT code 90791(X2) rendered on November 15, 2018?

Findings

1. Based upon the submitted documentation the requestor billed \$500.00 and was paid \$111.08 for code 90791 (X2) based upon "P13-Payment reduced/denied based on state WC regs/policies, and RAI-Medical Unlikely Edit; DOS exceeds MUE value."
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. 28 Texas Administrative Code §134.203(a)(7) states, "Specific provisions contained in the Texas Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by CMS in administering the Medicare program."

The division finds the respondent's reduction of payment is based upon limits of treatment/testing outlined in CMS's MUEs. These MUEs were not adopted by the division in 28 Texas Administrative Code §134.203; therefore, they do not apply in this case.

6. On the disputed date of service, the requestor billed codes 90791, 96101 and 99082. Only code 90791 is in dispute.
7. The requestor contends that reimbursement is due because "The patient was approved for 2 hours of Psychiatric Diagnostic Interview & 3 hours of Psychological Testing." In support of the position, the requestor submitted a copy of the preauthorization report that indicates codes 90791 and 96101 were approved. Regarding the number of units approved for code 90791, the report does not list 2 hours of testing, it just lists the code.
8. The respondent states that "Corvel will maintain the requestor...is not entitled to additional reimbursement for date of service 11/15/18; CPT Code 90791 based on DWC adopted fee guideline, Medicare payment policies and correct coding initiative (CCI) edits in effect at the time services were provided."
9. CPT code 90791 is defined as "Psychiatric diagnostic evaluation."
10. 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 \$111.08. As a result, additional reimbursement of \$111.08 is recommended.

Conclusion

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 \$111.08.

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 \$111.08 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	07/11/2019
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.