TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
NUEVA VIDA BEHAVIORAL HEALTH

Respondent Name
NATIONAL INTERSTATE INSURANCE

MFDR Tracking Number
M4-20-1058-01

Carrier's Austin Representative
Box Number 06

MFDR Date Received
December 27, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Authorization #127167602-UMO-6 was issued for the 6 sessions with a date range of 12/19/18-3/19/19… This date of service was performed within the authorized timeframe and was denied in error."

Amount in Dispute: $550.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Nueva seeks treatment for non-compensable conditions… As the disputed services concern treatment for non-compensable conditions, this dispute should be dismissed."

Response Submitted by: Burns Anderson Jury & Brenner, L.L.P.

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount in Dispute	Amount Due
February 4, 2019 through March 21, 2019	90837 x 4	$550.00	$412.50

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code (TLC) §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
3. 28 TAC §134.203 sets out the fee guidelines for professional medical services provided in the Texas workers' compensation system.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 350 & W3 – Bill has been identified as a request for reconsideration or appeal
   - 95 – Plan procedures not followed
   - A04 – Adjuster manual override of bill review reduction
   - U01 – There was no UR procedure/treatment request received
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline
   - P12 – Workers' Compensation jurisdictional fee schedule adjustment
   - U05 – the billed service exceeds the UR amount authorized

Issue(s)

1. Did the respondent raise new denial reasons or defenses in their position statement?
2. Did the requestor submit documentation to support that CPT Code 90837 rendered on February 4, 2019 through March 21, 2019 were preauthorized?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Code 90837 rendered on February 4, 2019 through March 21, 2019. The insurance carrier's position summary states in part, "As the disputed services concern treatment for non-compensable conditions, this dispute should be dismissed."

   The insurance carrier denied the disputed services with denial reduction codes:
   - 350 & W3 – Bill has been identified as a request for reconsideration or appeal
   - 95 – Plan procedures not followed
   - A04 – Adjuster manual override of bill review reduction
   - U01 – There was no UR procedure/treatment request received
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline
   - P12 – Workers' Compensation jurisdictional fee schedule adjustment
   - U05 – the billed service exceeds the UR amount authorized

   Review of the insurance carrier's response finds new denial reasons or defenses raised that were not presented to the requestor before the filing of the request for medical fee dispute resolution. 28 TAC §133.307(d)(2)(B) requires that upon receipt of the request for medical fee dispute resolution, the respondent shall provide any missing information not provided by the requestor and known to the respondent, including: a paper copy of all initial and appeal EOBs related to the dispute, as originally submitted to the health care provider... related to the health care in dispute not submitted by the requestor or a statement certifying that the respondent did not receive the health care provider's disputed billing prior to the dispute request. Review of the submitted information finds no documentation to support any EOBs were presented to the health care provider giving notice of the new denial reasons or defenses raised in the insurance carrier's response to MFDR.

   Rule §133.307(d)(2)(F) requires that:

   > The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.

   Pursuant to Rule §133.307(d)(2)(F), the insurance carrier's failure to give notice to the health care provider of specific codes or explanations for reduction or denial of payment as required by Rule §133.240 constitutes grounds for the division to find a waiver of defenses during Medical Fee Dispute Resolution.

   Upon review of the insurance carrier response, the division finds the respondent has raised new denial reasons or defenses of which the carrier failed to give notice to the health care provider during the bill review process or before the filing of this dispute. Consequently, the division concludes the insurance carrier has waived the right to raise new denial reasons or defenses during dispute resolution. Any such new defenses or denial reasons will not be considered in this review.

2. 28 Texas Administrative Code §134.600 states in pertinent part, "(p) Non-emergency health care requiring preauthorization includes... (7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or division exempted return-to-work rehabilitation program."

   Review of the submitted preauthorization letter dated December 24, 2018 issued by CorVel finds the following:

Requested	Individual/psychotherapy 6 sessions over 8 wks.
Certified	Individual/psychotherapy 6 sessions over 8 wks.
Effective date	12/19/18
Termination Date	3/19/19
CorVel Reference Number	127167206-UMO-6 Prospective

   The requestor rendered CPT Code 90837 on March 21, 2019, after the termination date provided on the preauthorization letter (see above). The DWC finds that the requestor is not entitled to reimbursement for this date of service, as it exceeds the timeframe provided in the preauthorization letter.

The requestor rendered CPT Code 90837 on February 4, 2019, March 4, 2019 and March 13, 2019 within the preauthorized timeframes, as a result, the Division finds that these disputed dates of service are reviewed per applicable Division rules and fee guidelines.

3. 28 Texas Administrative Code §134.203 states in pertinent part, "(c) 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..."

   28 Texas Administrative Code §134.203 states in pertinent part, "(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title."

   Procedure code 90837 rendered on February 4, 2019, has a MAR of $221.06. Per Rule §134.203(h), reimbursement is the lesser of the MAR or the provider's charge. The lesser amount is $137.50. Therefore, this amount is recommended.

   Procedure code 90837 rendered on March 4, 2019, has a MAR of $221.06. Per Rule §134.203(h), reimbursement is the lesser of the MAR or the provider's charge. The lesser amount is $137.50. Therefore, this amount is recommended.

   Procedure code 90837 rendered on March 13, 2019, has a MAR of $221.06. Per Rule §134.203(h), reimbursement is the lesser of the MAR or the provider's charge. The lesser amount is $137.50. Therefore, this amount is recommended.

4. Review of the submitted documentation finds that the requestor is entitled to a total recommended reimbursement amount of $412.50.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $412.50.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of TLC Sections 413.031 and 413.019 (if applicable), the DWC has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The DWC hereby ORDERS the respondent to remit to the requestor the amount of $412.50 plus applicable accrued interest per 28 TAC §134.130, due within 30 days of receipt of this Order.

Authorized Signature

______________________	______________________	February 21, 2020
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 TAC §133.307, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR 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 DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.