



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

NUEVA VIDA BEHAVIORAL HEALTH

Respondent Name

IMPERIUM INSURANCE CO

MFDR Tracking Number

M4-20-1225-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

JANUARY 16, 2020

REQUESTOR'S POSITION SUMMARY

"According to Texas Medical Fee Guidelines, the CPT code 96152 considers psychological interventions as necessary to address non-compliance with the treatment plan, and/or the psychological, behavioral, emotional, cognitive, or social factors associated with a newly diagnosed medical condition or an exacerbation of an established medical condition, when such factors affect symptom management and expression and health promoting behaviors. Further, the Health and Behavioral Intervention (96152) is described as an individual face-to-face (4 units at 15 minutes each), session that does not require pre-authorization."

Email dated March 2, 2020: "All but May 7th has been paid."

Email dated April 1, 2020: "Yes, the Carrier paid for all DOS except for 5/7/19. What do I need to do to obtain payment for the last date of service."

Amount in Dispute: \$137.50

RESPONDENT'S POSITION SUMMARY

"On January 16, 2020, the provider filed a DWC-60 seeking Medical Fee Dispute Resolution for service dates of April 19th, April 26th and May 7, 2019. The carrier has previously processed the provider's bill but is going to reprocess them and will be paying them pursuant to the Medical Fee Guidelines. We would ask that the provider withdraw its request for Medical Fee Dispute Resolution or that the Division dismiss it once the provider has received payment. This is on the basis that the medical fee dispute will have resolved."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 19, 2019 April 26, 2019	CPT Code 96152 (X4 Units)	\$137.50/each date	Insurance Carrier Paid and is not in dispute
May 7, 2019			\$137.11

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 (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307, effective May 31, 2012, sets out the procedures for resolving medical fee disputes.
2. 28 TAC §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 claim adjustment reason codes:
 - 39-Services denied at the time authorization/pre-certification was requested.
 - 5565-preauthorization requested but denied.
 - 269-This billing is for a service unrelated to the work illness or injury.
 - P2-Not a work related injury/illness and thus not the liability of the workers' compensation carrier.
 - W3-Additional payment made on appeal/reconsideration.

Issues

Is the requestor entitled to reimbursement for CPT code 96152 rendered on May 7, 2019?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of \$137.50 for CPT code 96152 rendered on May 7, 2019.
2. The respondent initially denied reimbursement for CPT code 96152 based upon a lack of preauthorization. Upon reconsideration, the respondent denied payment based upon unrelated to work injury. Then, in response to this request for medical fee dispute resolution, the respondent wrote, "The carrier has previously processed the provider's bill but is going to reprocess them and will be paying them pursuant to the Medical Fee Guidelines." The DWC finds that reimbursement is due based upon the respondent's decision to pay.
3. The fee guideline for disputed services is found at 28 TAC§134.203.
4. 28 TAC §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."
5. 28 TAC §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."
6. Per 28 TAC §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 DWC had been using this MEI annual percentage adjustment: The 2006 DWC 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) DWC 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 2019 DWC conversion factor for this service is 59.19.

The Medicare Conversion Factor is 36.0391

Review of Box 32 on the CMS-1500 the services were rendered in San Antonio, Texas; therefore, the Medicare locality is "Rest of Texas".

The Medicare participating amount for code 96152 at this locality is \$20.87.

Using the above formula, the MAR is \$34.81 X 4 units = \$137.11. The respondent paid \$0.00. The DWC finds, the requestor is due reimbursement of \$137.11.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$137.11.

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 \$137.11, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		04/10/2020
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 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 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 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 DWC. **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.