



**Texas Department of Insurance**

**Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48  
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645  
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**MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

**GENERAL INFORMATION**

**Requestor Name**

TX HEALTH DBA INJURY 1 OF DALLAS

**Respondent Name**

WESTFIELD INSURANCE CO

**MFDR Tracking Number**

M4-20-1462-01

**Carrier's Austin Representative**

Box Number 22

**MFDR Date Received**

FEBRUARY 11, 2020

**REQUESTOR'S POSITION SUMMARY**

"Enclosed are copies of the EOBs (1<sup>st</sup> & 2<sup>nd</sup> denials), claims, and documentation. The patient was approved for services. The services were provided and the bills were denied per EOB unnecessary treatment based on peer review...it is our position that Broadspire has established an unfair and unreasonable time frame in paying for the services that were medically necessary and rendered to [Claimant]."

**Amount in Dispute:** \$1,409.64

**RESPONDENT'S POSITION SUMMARY**

"Medical fee dispute resolution is not the correct venue for this dispute as this is an extent of injury dispute."

**Response Submitted by:** Broadspire

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 15, 2019	CPT Code 90837	\$221.06	\$221.06
November 18, 2019	CPT Code 90837	\$221.06	\$221.06
November 19, 2019	CPT Code 96138	\$64.68	Not Eligible for Medical Fee Dispute Resolution
	CPT Code 96139	\$419.16	
	CPT Code 96130	\$191.76	
	CPT Code 96131	\$291.92	
TOTAL		\$1,409.64	\$442.12

**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 §133.307 (TAC), effective May 31, 2012, sets out the procedures for resolving a medical fee dispute.
2. 28 TAC §134.600, effective November 1, 2018, requires preauthorization for specific treatments and services.
3. 28 TAC §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
4. 28 Texas Administrative Code §133.305, effective March 30, 2014, sets out general medical dispute resolution guidelines.
5. 28 Texas Administrative Code §141.1, effective October 1, 2010 sets out the procedure for requesting a Benefit Review Conference.
6. Texas Labor Code §408.021 sets out provisions regarding entitlement to medical benefits.
7. Texas Labor Code §413.031 sets out provisions regarding medical dispute resolution.
8. Texas Labor Code Chapter 410 sets out provisions regarding adjudication of disputes.
9. Per the submitted explanation of benefits, the services in dispute were reduced/denied payment by the respondent with the following claim adjustment reason codes:

Date of Service November 15 and 18, 2019

- V-Unnecessary Treatment (w/Peer Review).
- D51-Unnecessary Treatment based on peer review.

Date of Service November 19, 2019

- V-Unnecessary Treatment (w/Peer Review).
- D51-Unnecessary Treatment based on peer review.
- D53-Extent of injury not finally adjudicated.
- W3-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- D00-Based on further review, no additional allowance is warranted.

## **Issues**

1. Does a medical necessity issue exist in this dispute? Is the requestor entitled to reimbursement for services rendered November 15 and 18, 2019?
2. Does a extent of injury issue exist in this dispute? Are the services rendered on November 19, 2019 eligible for medical fee dispute resolution?

## **Findings**

The requestor is seeking medical fee dispute resolution in the amount of \$1,409.64.00 for CPT codes 90837, 96138, 96139, 96130, and 96131 rendered from November 15 through November 19, 2019.

1. Date of Service November 15 and 18, 2019
  - The respondent denied reimbursement for CPT code 90837 rendered on November 15 and 18, 2019 based upon medical necessity.
  - The requestor contends that a medical necessity issue does not exist because preauthorization was obtained #733966 & #739314.
  - In support of their position, the requestor submitted two preauthorization reports, that authorize four Individual Psychotherapy sessions and Psychological testing, evaluation, interpretation, report and feedback.
  - CPT code 90837 is described as "Psychotherapy, 60 minutes with patient."
  - 28 TAC §134.600(I) states, "The insurance carrier shall not withdraw a preauthorization or concurrent utilization review approval once issued."
  - The DWC finds the respondent's denial based upon medical necessity is not supported and reimbursement is recommended per the fee guideline.
  - The fee guidelines for disputed services is found at 28 TAC §134.203.

- 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 Medicare Payment = Maximum Allowable Reimbursement (MAR).

- The 2019 DWC Conversion Factor is 59.19
- The 2019 Medicare Conversion Factor is 36.0391
- The services were rendered in zip code 75243, which is located in Dallas, Texas; therefore, the Medicare participating amount is based on locality “Dallas, Texas”.
- The Medicare participating amount for code 90837 at this location is \$137.67.

Using the above formula, the DWC finds the MAR is \$226.11 or less The requestor is seeking \$221.06. The requestor billed for two units of code 90837; therefore, \$221.06 X2 = \$442.12 The respondent paid \$0.00. The requestor is due the difference between MAR and amount paid of \$442.12.

2. Date of Service November 19, 2019.

- The respondent denied reimbursement for *CPT* codes 96138, 96139, 96130, and 96131 rendered on November 19, 2019 based upon extent of injury.
- 28 TAC §133.305(b) requires that If a dispute regarding compensability, extent of injury, or liability exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, or liability shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §408.021 and Chapter 410.
- Upon review of the submitted information, the DWC finds the insurance carrier has denied payment for the health care for reasons related to the extent of injury or liability for the disputed services. The carrier’s explanation of benefits was timely presented to the requestor in accordance with the requirements of 28 Texas Administrative Code §133.240.
- The DWC concludes there is an outstanding dispute regarding the extent of injury or liability for the disputed services. Consequently, the medical fee issues in dispute are not eligible for review until the related extent of injury or liability issues have been finally adjudicated in accordance with the provisions of Texas Labor Code Chapter 410.
- The DWC hereby notifies the requestor that the process for resolving disputes regarding the extent of injury or liability for health care is found in Texas Labor Code Chapter 410 and corresponding DWC rules in 28 Texas Administrative Code Chapter 141.
- To resolve this matter, the requestor may file the required Form DWC045, Request to Schedule, Reschedule, or Cancel a Benefit Review Conference (BRC), or to Proceed Directly to Contested Case Hearing (CCH) with the field office handling the claim. A copy of Form DWC045 may be downloaded from the TDI-DWC website at [www.tdi.texas.gov/forms/](http://www.tdi.texas.gov/forms/).
- 28 TAC §133.307(f)(3) states that a dismissal is not a final decision by the DWC. The requestor has the right to submit a new request for medical fee dispute resolution after the compensability, extent of injury, or liability issues have been resolved.
- The requestor is responsible for filing any new request for medical fee dispute resolution not later than one year after the dates of service in dispute or not later than 60 days after the date the requestor receives an

approved agreement or final decision resolving the disputed compensability, extent of injury, or liability issues.

- The 60-day filing requirement described in Rule §133.307(c)(1)(B)(i) extends the one-year MFDR filing deadline in those cases where a related compensability, extent of injury, or liability dispute has been filed under Texas Labor Code Chapter 410 for the same services subject to medical fee dispute.

## CONCLUSION

For the reasons stated above, the DWC finds that the requestor has established that reimbursement is due for dates of service November 15 and 18, 2019 in the amount of \$442.12. As stated above, date of service November 19, 2019 is not eligible for medical fee dispute resolution.

## 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 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 \$442.12 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

## Authorized Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

03/26/20201  
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, 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 TAC §141.1(d).

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