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
LIBERTY INSURANCE CORP

MFDR Tracking Number
M4-20-2193-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
May 5, 2020

Response Submitted by:
Liberty Mutual Insurance

REQUESTOR'S POSITION SUMMARY

"According to the OGD [sic] Guidelines that we have installed in our system it does not state anything about having to get pre-authorization for the Range of Motion Testing. If there is something says that we need pre auth please send it to me in writing or where we can find it in on the ODG guidelines."

RESPONDENT'S POSITION SUMMARY

"Payment for 1 unit of CPT of 95831 and 95832 is appropriate as additional units are denied due to excessiveness or frequency of treatment… code 95851 is already covered by 95831, so they are not allowed to be billed together. Disallow-Allowance. $0.00."

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount in Dispute	Amount Due
May 28, 2019	95831, 95832 and 95851	$1,380.00	$985.15

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 §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the guidelines for billing and reimbursement of professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - B15 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
   - 309 – The charge for this procedure exceeds the fee schedule allowance
   - W3 – Additional payment made on appeal/reconsideration
   - 906 – In accordance with clinical based coding edits (national correct coding initiative/outpatient code editor). Component code of comprehensive medicine, evaluation and management services procedure (90000-99999) has been disallowed

- 5833 – Charge denied due to excessiveness or frequency of treatment

Issue(s)

1. Did the insurance carrier support the medical necessity denial for CPT Codes 95831 and 95832?
2. Is denial reason "906" supported for CPT Code 95851?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied/reduced CPT Codes 95831 and 95832 with denial reduction code "5833 – Charge denied due to excessiveness or frequency of treatment."

   The insurance carrier states in pertinent part, "Payment for 1 unit of CPT of 95831 and 95832 is appropriate as additional units are denied due to excessiveness or frequency of treatment."

   Per 28 TAC 133.307 (d)(2)(I) states in pertinent part, "Responses. Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division. (2) Response. Upon receipt of the request, the respondent shall provide any missing information not provided by the requestor and known to the respondent. The respondent shall also provide the following information and records: (I) If the medical fee dispute involves medical necessity issues, the insurance carrier shall attach a copy of documentation that supports an adverse determination in accordance with §19.2005 of this title (relating to General Standards of Utilization Review)."

   The requestor did not submit documentation to support the denial of excessiveness or frequency of treatment as required per Rule 133.307 (d)(2)(I), as a result, the DWC finds that the insurance carrier's denial reason is not supported for CPT Codes 95831 and 95832 and the disputed services are therefore reviewed pursuant to the applicable rules and guidelines.

2. The insurance carrier denied/reduced CPT Code 95851 with denial reduction code "906-In accordance with clinical based coding edits (national correct coding initiative/outpatient code editor). Component code of comprehensive medicine, evaluation and management services procedure (90000-99999) has been disallowed."

   Per 28 TAC §134.203 states, "(b) 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."

   The DWC completed CCI edits to identify potential edit conflicts that may affect reimbursement. Review of the CMS1600 for date of service May 28, 2019 finds that the requestor billed CPT Codes 95831, 95832 and 95851: The following was identified:

   - Per Medicare CCI Guidelines, procedure code 95851 has an unbundle relationship with history procedure code 95831

   The DWC finds that the insurance carrier's denial reason is supported for CPT code 95851 and is therefore not entitled to reimbursement for CPT Code 95851. As a result, $0.00 is recommended.

3. Reimbursement for CPT Codes 95831 and 95832 is found in 28 TAC §134.203 , which state in relevant part, "(b) 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… (c) … (2) … Subsequent year's conversion factors shall be determined by apply 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."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = Maximum Allowable Reimbursement (MAR). The division finds the following:

Reimbursement for CPT Codes 95831 and 95832

- The 2019 DWC Conversion Factor is 59.19
- Place of service "11"
- The 2019 Medicare Conversion Factor is 36.0391
- The services were rendered in zip code 78224 located in San Antonio, Texas; therefore, the Medicare carrier locality is "Rest of Texas." Medicare participating amount at this locality is $31.57
- CPT Code 95831 – Using the above formula, the DWC finds the MAR for CPT Code 95831 is $51.85/unit. The requestor billed for 20 units; therefore, 20 X $51.85 = $1,037.00. The respondent paid for 1 (one) unit at $51.85. As a result, the requestor is due the difference between the MAR and amount paid of $985.15.
- CPT Code 95832 – Using the above formula, the DWC finds the MAR is $51.26. The requestor billed 1 (one) unit; the respondent paid for 1 (one) unit at $51.26. As a result, the requestor is not entitled to additional reimbursement for CPT Code 95832.

The DWC finds that the requestor is entitled an additional reimbursement amount of $985.15. Therefore, this amount is recommended.

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 $985.15.

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 $985.15 plus applicable accrued interest per 28 TAC §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		May 29, 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.