



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

REDWOOD FIRE & CASUALTY INSURANCE COMPANY

MFDR Tracking Number

M4-21-0614-01

Carrier's Austin Representative

Box Number 12

MFDR Date Received

December 1, 2020

Response Submitted by:

Stone Loughlin & Swanson

REQUESTOR'S POSITION SUMMARY

"According to Texas Medical Fee Guidelines, the CPT code 96158/96159 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 Behavior Intervention (96158/96159) is described as an individual session that does not require pre-authorization."

RESPONDENT'S POSITION SUMMARY

"Claimant's injury is limited to a left knee/leg injury. Behavioral and/or cognitive therapy is not recommended treatment under the Knee and Leg Chapter of the Official Disability Guidelines {ODG}, a true and correct copy of which is attached hereto as Exhibit 2. See 28 Tex. Admin. Code §134.600(p)(12) (requiring preauthorization for "treatments and services that exceed or are not addressed by the Commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the carrier."). Therefore, pre-authorization was required under this subsection..."

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount in Dispute	Amount Due
January 20, 2020	96158 & 96159	\$160.00	\$0.00

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 §137.100, sets out the treatment guidelines.
4. 28 TAC §134.203, sets out the fee guidelines for reimbursement of professional medical services.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
- No additional reimbursement allowed after review of appeal/reconsideration
 - The procedure or supply requires prior authorization or approval

Issue(s)

1. What is the definition of CPT Code 96152?
2. Does the dispute service require preauthorization?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks payment for CPT Code 96152 rendered on January 20, 2020.

28 TAC §134.203 (b) states in pertinent part, “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.”

CPT Code 96152 is defined as “Health and behavior intervention, each 15 minutes, face-to-face; individual.”

2. The responded denied the disputed service based on lack of preauthorization.

28 TAC §134.600 states, “28 TAC §134.600(p)(12) requires preauthorization for “treatments and services that exceed or are not addressed by the Commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the carrier.”

According to the Knee Chapter of the *Official Disability Guidelines* (ODG), behavioral treatment is not recommended; therefore, the disputed health and intervention services required preauthorization. The respondent’s denial of payment based upon a lack of preauthorization is supported.

3. Review of the submitted documentation finds that the requestor is not entitled to reimbursement for the services in dispute.

Conclusion

For the reasons stated above, the DWC finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of TLC §413.031, the DWC has determined that the requestor is not entitled to reimbursement for the disputed services.

Authorized Signature

_____	_____	January 14, 2021
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 prefieres hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.