



# 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](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

NUEVA VIDA BEHAVIORAL HEALTH

**Respondent Name**

BITCO GENERAL INSURANCE CO

**MFDR Tracking Number**

M4-21-1138-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

MARCH 9, 2021

#### REQUESTOR'S POSITION SUMMARY

"...the Health and Behavior Intervention (96158/96159) is described as an individual session that does not require preauthorization."

**Amount in Dispute:** \$170.00

#### RESPONDENT'S POSITION SUMMARY

"The carrier denied the provider's bill on the basis of a lack fo preauthorization. It is the carrier's position that the services in question require preauthorization. The absence of it, disallows any reimbursement."

**Response Submitted by:** Flahive, Ogden & Latson

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 13, 2020	CPT Code 96158	\$93.50	\$93.50
	CPT Code 96159 (X2)	\$76.50	\$76.50
TOTAL		\$170.00	\$170.00

#### 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. Per the submitted explanation of benefits, the services in dispute were reduced/denied by the respondent with the following claim adjustment reason codes:

- 197-Payment adjusted for absence of precert/preauth
- W3-Appeal/Reconsideration

## **Issues**

Is the requestor entitled to reimbursement for services rendered on April 13, 2020?

## **Findings**

1. The requestor is seeking medical fee dispute resolution in the amount of \$170.00 for psychological care services rendered to the injured worker on April 13, 2020.
2. The insurance carrier denied reimbursement for the disputed services, CPT codes 96158 and 96159, based upon an absence of precertification/authorization.

Per 28 TAC §134.600(p) (7) states, "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 return-to-work rehabilitation program."

- CPT code 96158 is described as "Health behavior intervention, individual, face-to-face; initial 30 minutes."
- CPT code 96159 is described as "Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)."

Based upon the code description, the disputed services are not listed in the above rule; therefore, the respondent's denial based upon a lack of preauthorization is not supported. The DWC finds the requestor is due reimbursement for the disputed services.

3. 28 TAC §134.203(c)(1) states, "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."

28 TAC §134.203(c)(2) states, "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 Division had been using this MEI annual percentage adjustment: The 2006 Division 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) Division 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 2020 DWC Conversion Factor is 60.32

The 2020 Medicare Conversion Factor is 36.0896

Review of Box 32 on the CMS-1500 the services were rendered in San Antonio, Texas; therefore, the locality will be based on the rate for "Rest of Texas".

The Medicare Participating amount for CPT code 96158 at this locality is \$66.90 and \$23.33 for 96159.

Using the above formula, the DWC finds:

Code	Medicare Participating Amount	No. Of Units	MAR
96158	\$66.90	1	\$111.82 or less. The requestor is seeking lesser amount of \$93.50
96159	\$23.33	2	\$38.99 X 2 = \$77.99 or less. The requestor is seeking lesser amount of \$76.50

As a result, reimbursement of \$170.00 is recommended.

### **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 \$170.00.

### ***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 \$170.00 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

04/05/2021  
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.**