TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
NUEVA VIDA BEHAVIORAL HEALTH

Respondent Name
NEW HAMPSHIRE INSURANCE COMPANY

MFDR Tracking Number
M4-21-2460-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
August 30, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 7, 2021 through April 1, 2021	90837 x 4	$560.00	$0.00
	Total	$560.00	$0.00

Requestor's Position

"Nueva Vida obtained preauthorization for 8 sessions of Individual Psychotherapy on 2/09/2021. Authorization #4027877 was issued for the 8 sessions with a date range of 2/09/21 - 7/09/21... This date of service was performed within the authorized timeframe and was denied in error. Denying preauthorized health care services is an administrative violation in accordance."

Amount in Dispute: $560.00

Respondent's Position

"Carrier asserts that reimbursement is not owed for these service dates, as Provider has not presented evidence that the services were pre-authorized as required by 28 TAC 134.600."

Response Submitted by: Flahive, Ogden & Latson

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

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 procedure for Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care.

Denial Reasons

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:

- 5264 – Payment is denied service not authorized
- 197 – Payment denied/reduced for absence of precertification/authorization
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

Issues

1. What is the definition of CPT code 90837?
2. Is the insurance carrier's denial reason supported?

Findings

1. The requestor seeks reimbursement for CPT Code 90837 rendered on January 7, 2021 through April 1, 2021.

   Per 28 Texas Administrative Code §134.203 "(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 AMA CPT Code Book defines CPT code 90837 as "Psychotherapy, 60 minutes with patient and/or family member."

2. The carrier denied the disputed service with denial reasons 5264 and 197 (description provided above.) Per 28 Texas Administrative Code §134.600 "(p) 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 or division exempted return-to-work rehabilitation program."

   The requestor refers to authorization #4027877 issued for 8 sessions of psychotherapy, with a date range of 2/09/21 - 7/09/21. However, the requestor did not include a copy of the preauthorization letter with the DWC060 to support that preauthorization was obtained for the services in dispute.

   28 Texas Administrative Code §134.600 states in relevant part, "(c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care."

   The DWC finds that the requestor submitted insufficient documentation to support that preauthorization was obtained for the services in dispute and therefore the insurance carrier's denial reason is supported.

   The requestor is therefore not entitled to reimbursement for the services in dispute and therefore, $0.00 is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to reimbursement for the disputed services.

Authorized Signature

		October 4, 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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.