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
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-22-0124-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
September 22, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 25, 2020	99204	$220.00	$0.00
	Total	$220.00	$0.00

Requestor's Position

"The consultation for psychotropic medication does not require preauthorization. The Date of Service being denied for payment is 9/25/2020. Please reprocess the attached claim and supporting documentation for payment. Thank you in advance for your prompt assistance in this matter."

Amount in Dispute: $220.00

Respondent's Position

"The providers position statement asserts that the psychiatric consult does not require preauthorization... Documentation submitted confirms that the rendering provider completed a psychiatric evaluation. The provider billed 99204 with modifier 95. Audit staff denied the bill with 714 reason code with an explanation to the provider that the services rendered does not support an office visit. (see DWC60). Per AMA/CPT coding guidelines there is a more accurate cpt code for a psychiatric evaluation. Texas Mutual maintained the denial for an accurate cpt code directed per 714 reason code. No payment due."

Response Submitted by: Texas Mutual Insurance Company

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 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §133.20 sets out the guidelines for medical bill submission by health care providers.

Denial Reasons

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

- 714 - DOCUMENTATION SUPPORTS SERVICES RENDERED ARE FOR A PSYCHIATRIC EVALUATION NOT AN OFFICE VISIT
- CAC-P12 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- CAC-W3 - IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- CAC-18 - EXACT DUPLICATE CLAIM/SERVICE
- CAC-193 - ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- DC4 - NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER RECONSIDERATION.
- DC7 - DUPLICATE APPEAL. NETWORK CONTRACT APPLIED BY WORKWELL, TX NETWORK.
- 350 - IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUESTFOR RECONSIDERATION OR APPEAL.
- 714 - ACCURATE LICENSE, CPT/HCPCS, DATES, UNITS, DAYS SUPPLY, MODIFIERS ARE ESSENTIAL FOR REIMBURSEMENT. SUBMIT CORRECTIONS W/I 95 DAYS FROM DOS.

Issues

1. Is the Insurance Carrier's denial reason(s) supported?
2. Is the Requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Code 99204 rendered on September 25, 2020. The insurance carrier denied the disputed service with denial reduction codes, 714 (description provided above.)

   Per 28 TAC 133.20 (c), "(c) A health care provider shall include correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitting medical bills."

Review of the documentation submitted by the requestor, titled "Initial Psychiatric Assessment." Review of the AMA CPT code book supports that a CPT code exists for the service rendered. Per rule 133.20, a health care provider shall include correct billing codes from the applicable Division fee guidelines in effect on the date of service when submitting a medical bill.

2. The DWC finds that the insurance carrier denial reason is supported and therefore is not entitled to reimbursement for disputed CPT code 99204 rendered on September 25, 2021.

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.

The DWC finds that the requester has not established that reimbursement of $220.00 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

		November 5, 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.