



Medical Fee Dispute Resolution Findings and Decision General Information

Requestor Name

NUEVA VIDA BEHAVIORAL HEALTH

Respondent Name

TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number

M4-22-0761-01

Carrier's Austin Representative

Box Number 54

DWC Date Received

December 21, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 18, 2021 through April 14, 2021	96158, 96159 and 90837 x 3	\$584.00	\$584.00
Total		\$584.00	\$584.00

Requestor's Position

"Nueva Vida is submitting this claim in Accordance to Rule 133.20, Section D of Subsection 2..."

Amount in Dispute: \$584.00

Respondent's Position

"To resolve this fee reimbursement dispute, Texas Mutual has elected to reprocess the disputed services in accordance with the appropriate Medical Fee Guideline as defined per Texas Administrative Code Rule 134 - Guidelines for Medical Services, Charges and Payments."

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 §134.203 sets out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.

Denial Reasons

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

- Note: PROVIDER NEEDS TO UPDATE INFORMATION TO MATCH BOX 24 AND BOX 31 OF THE HCFA TO REFLECT THE RENDERING PROVIDERS INFORMATION. (ALEXIS BARRERAS, LPC). PLEASE CORRECT AND SUBMIT A REQUEST FOR RECONSIDERATION.
- A19 – DWC RULES 133.10, 133.20 & CLEAN CLAIM GUIDE REQUIRE LICENSE TYPE, NUMBER & JURISDICTION OF LICENSED HCP WHO RENDERED SERVICES.
- CAC-P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- CAC-W3& 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- 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.

Issues

1. Does the insurance carrier continue to dispute the services identified on the DWC060?
2. What is the definition of CPT Codes 96158, 96159 and 90837?
3. Is the requestor entitled to reimbursement for CPT Codes 96158, 96159 and 90837?

Findings

1. The requestor seeks reimbursement for CPT Codes 96158, 96159 and 90837 rendered on March 18, 2021 through April 14, 2021. The insurance carrier states, "To resolve this fee reimbursement dispute, Texas Mutual has elected to reprocess the disputed services in accordance with the appropriate Medical Fee Guideline as defined per Texas Administrative Code Rule 134 - Guidelines for Medical Services, Charges and Payments."

The DWC contacted the requestor on April 13, 2022 to verify receipt of payment, the requestor indicated that payment has not been received. The DWC contacted the insurance carrier for payment status, and the insurance carrier indicated on June 2, 2022, "Yes, these have errored out due to closed status. I have updated Shawna on the issue and will provide once again new invoice numbers once re-opened."

The DWC finds that the insurance carrier no longer disputes the services indicated on the DWC060, as a result, the disputed services are reviewed for reimbursement pursuant to the applicable rules.

2. 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 96158 is defined as "Health behavior intervention, individual, face-to-face; initial 30 minutes."
 - CPT Code 96159 is defined as "Health behavior intervention, individual, face-to-face; each additional 15 minutes."
 - CPT Code 90837 is defined as "Psychotherapy, 60 minutes with patient and/or family member."

3. The requestor seeks reimbursement for CPT Code 96158 and 96159 rendered on March 18, 2021 and CPT Code 90837 rendered on March 26, 2021 through April 14, 2021.

28 TAC §134.203 (c) states in pertinent part, "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. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32. (2) 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..."

28 TAC §134.203 states in pertinent part, "(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title."

The following formula represents the calculation of the DWC MAR:

$(\text{DWC Conversion Factor} \div \text{Medicare Conversion Factor}) \times \text{Medicare Payment} = \text{MAR}$.

- The services were provided in zip code 78230
- The locality for San Antonio, TX is "Rest of Texas."
- The DWC Conversion factor for 2021 is 64.17.
- The Medicare Conversion factor for 2021 is 34.8931.

Reimbursement is recommended as follows:

Date of service	CPT Code	# Units	Amount Sought	MAR	Amount Recommended
3/18/2021	96158	1	\$80.00	\$114.44	\$80.00
	96159	2	\$72.00	\$78.96	\$72.00
3/26/2021	90837	1	\$140.00	\$261.45	\$140.00
4/2/2021	90837	1	\$140.00	\$261.45	\$140.00
4/14/2021	90837	1	\$152.00	\$261.45	\$152.00
TOTAL		6	\$584.00	\$977.75	\$584.00

Review of the submitted documentation finds that the total MAR is \$977.75. The insurance carrier paid \$0.00. The requestor seeks \$584.00, applicable 28 TAC §134.203(h) states that the total reimbursement is the lesser of the maximum allowable reimbursement (MAR) and the billed amount, as a result the requestor is entitled to \$584.00.

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 the requester has established that reimbursement of \$584.00 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requestor \$584.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

June 28, 2022
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 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 electrónico CompConnection@tdi.texas.gov.