TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
NUEVA VIDA BEHAVIORAL HEALTH

Respondent Name
SAFETY NATIONAL CASUALTY COMPANY

MFDR Tracking Number
M4-23-1504-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
February 27, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 22, 2022 through September 6, 2022	96158 and 96159	$1,720.00	$1,590.17
	Total	$1,720.00	$1,590.17

Requestor's Position

"Please review the attached claim, which was denied per 'Referring provider is not eligible to refer the service billed.' Please see additional information, for proof of Approved Provider change."

Amount in Dispute: $1,720.00

Respondent's Position

"Rule 134.600(p)(7) requires preauthorization for all psychological testing and psychotherapy, repeat interviews and biofeedback, except when any service is part of a preauthorized returned to work rehabilitation program. Moreover, the treatment and services either exceed or are not addressed by the Commissioners adopted treatment guidelines and thus should not be reimbursed under rule 134.600(p)(12). The services were not provided as part of a return-to-work rehabilitation program. Accordingly, preauthorization was required. However, preauthorization was not obtained. The services were denied on that basis. That remains the carrier's position. The provider is not entitled to any payment for the services in question."

Response Submitted by: Medata Service Operations

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 guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
3. 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:

- P12 – The charge for the procedure exceeds the amount indicated in the fee guideline.
- T183 – The referring provider is not eligible to refer the service billed.
- W3 – No additional reimbursement allowed after review of appeal/reconsideration.
- T197 – Payment denied/reduced for absence of or exceeded pre-certification and/or authorization.
- T113 – Level 1 appeal means a request for reconsideration under 133.250.
- T039 – Services denied at the time authorization/precertification was requested.
- Note: Workers' compensation medical treatment guideline adjustment.
- T051 – These services are non-covered services because this is a pre-existing condition.
- Note: Precertification/authorization/notification pre-treatment absent.
- T185 – Rendering provider not eligible to perform services billed.
- GN08 – The prescribing physician is not the primary treating physician of record for this injury. There is no documentation from the prescribing physician to support these charges as industrially related to the above captioned injury.
- Note: Services not provided or authorized by designated (network/primary care providers.

Issues

1. What is the description of CPT Codes 96158 and 96159?
2. Who is the treating doctor on record?
3. Are the insurance carrier's denial reasons for lack of preauthorization supported?
4. Is the requestor entitled to reimbursement?

Findings

1. The requestor billed CPT codes 96158 and 96159 rendered on June 22, 2022 through September 6, 2022.

   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."
   - The disputed services are considered health and behavior assessment and intervention services.

2. The insurance carrier denied the disputed services with denial reduction codes;

   - T183 – The referring provider is not eligible to refer the service billed.
   - T185 – Rendering provider not eligible to perform services billed.
   - GN08 – The prescribing physician is not the primary treating physician of record for this injury. There is no documentation from the prescribing physician to support these charges as industrially related to the above captioned injury.
   - Note: Services not provided or authorized by designated (network/primary care providers.

   Review of the request to change treating doctor's commissioner order dated May 31, 2022 documents a change in treating doctor from James L. Bugg to Gilbert Gonzales. Review of box 17 of the CMS-1500 documents that the referring provider is Gilbert Gonzales, D.C.

   The DWC finds that the treating doctor on record referred the injured employee to Nueva Vida for services rendered. As a result, the insurance carrier's denial reasons indicated above are not supported. The disputed services are therefore reviewed pursuant to the applicable rules and guidelines.

3. The requestor seeks reimbursement for CPT Codes 96158 and 96159 rendered on June 22, 2022 through September 6, 2022. The insurance carrier states in pertinent part, "…preauthorization was not obtained. The services were denied on that basis. That remains the carrier's position."

   The insurance carrier denied the disputed services with denial reduction codes;

   - T197 – Payment denied/reduced for absence of or exceeded pre-certification and/or authorization
   - T039 – Services denied at the time authorization/precertification was requested
   - Note: Precertification/authorization/notification pre-treatment absent

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."

Review of the Official Disability Guidelines (ODG), Carpal Tunnel Syndrome section indicates that the disputed services are recommended, as a result, preauthorization is not required. The respondent's denial of payment based upon a lack of preauthorization is not supported.

The DWC finds that CPT Codes 96158 and 96159 are recommended and therefore are not subject to the preauthorization requirements in 28 TAC §134.600 (p)(7) and (p)(12). As a result, reimbursement is determined per 28 TAC §134.203.

4. 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..."

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = Maximum Allowable Reimbursement (MAR).

   - The 2022 DWC Conversion Factor is 62.46
   - The 2022 Medicare Conversion Factor is 34.6062
   - Per the medical bills, the services were rendered in zip code 78224; therefore, the Medicare locality is "Rest of Texas."

   The Medicare Participating amount for CPT code 96158 x 1 unit at this locality is $65.47.

   - Using the above formula, the DWC finds the MAR is $118.17 x 8 dates of service = total MAR of $945.32.
   - The respondent paid $0.00.
   - Reimbursement of $945.32 is recommended.

   The Medicare Participating amount for CPT code 96159 x 2 units at this locality is $22.33 x 2 units = $44.66.

   - Using the above formula, the DWC finds the MAR is $80.61 x 8 dates of service = total MAR of $644.85.
   - The respondent paid $0.00.
   - Reimbursement of $644.85 is recommended.

5. The DWC finds that the requestor has established that reimbursement is due. As a result, the requestor is entitled to $1,590.17 for the disputed services.

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 $1,590.17 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 $1,590.17 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		June 2, 2023
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 managing 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.