



## MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

### PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (x) Health Care Provider    () Injured Employee    () Insurance Carrier	
Requestor's Name and Address: Texas Health 5445 La Sierra, Suite 204 Dallas, TX 75231	MDR Tracking No.: M5-06-0872-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:  C/o Harris & Harris Rep Box #: 42	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

### PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Requestor's position summary states in part, "All services provided by our facility were pre-authorized by the Risk Management utilization review company. As you will see with further MDR requests, Risk Management is a habitual violator of TDI Rules and Regulations. They continually pay this procedure at a rate far below the TDI Fee Guideline..."

Principle Documentation:

1. Requestor's position statement
2. CMS-1500s
3. EOB's

### PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Respondent did not submit a response to the Request for Medical Dispute Resolution.

Principle Documentation: 1. N/A

### PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	Denial Code	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
03/07/05 & 03/14/05	122A	90806 – Psychotherapy	1	\$95.06
03/25/05, 03/30/05, 04/08/05	U	90806 – Psychotherapy	2	\$380.25
03/25/05, 03/30/05, 04/08/05		90880, 97003, 90889	3	\$00.00
<b>TOTAL DUE</b>				<b>\$475.31</b>

### PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Section 413.011(a-d) titled (Guidelines and Medical Policies), and Commission Rule 134.202 titled Medical Fee Guideline effective August 1, 2003, set out reimbursement guidelines.

1. CPT Code 90806 for dates of service 03/07/05 and 03/14/05 was denied as "122A – Psychiatric reduction". The denial code "122A" refers to an Outpatient Mental Health Limitation in which the carrier must apply the outpatient mental health limitation to all covered mental health therapeutic services furnished by PAs (Physician Assistant). Review of the CMS 1500 reveals the health care provider providing the treatment/services is not a Physician Assistant; therefore the Carrier has incorrectly denied the treatment and has not fully reimbursed the health care provider according to the 2002 Medical Fee Guideline. Per Rule 134.202(b) additional reimbursement in the amount of \$95.06 ( $\$101.40 \times 125\% = \$126.75 \times 2 = \$253.50 - 158.44$ ) is recommended.

2. CPT Code 90806 for dates of service 03/25/05, 03/30/05 and 04/08/05 was denied as "U – Unnecessary Medical w/o a Peer Review". The Requestor has submitted a preauthorization notification from Argus Services with a written notification date of

02/28/2005 preauthorizing individual psychotherapy 1xWKxWKS. Rule 133.301(a) states that an insurance carrier shall not retrospectively deny services that have been preauthorized; therefore, per Rule 134.202(b) reimbursement in the amount of \$380.25 (\$126.75 x 3) is recommended.

3. CPT Codes 90880, 97003 and 90889 for dates of service 03/25/05, 03/30/05, and 04/08/05 were denied as "U". These services were not preauthorized. The health care provider has chosen to withdraw these CPT codes from the dispute and has submitted correspondence withdrawing these codes. Therefore, these codes are no longer in dispute and will not be reviewed.

The total amount of reimbursement the requestor is entitled to be \$475.31.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION**

28 Texas Administrative Code Sec. §413.011(a-d)  
28 Texas Administrative Code Sec. §134.201  
28 Texas Administrative Code Sec. §134.202

**PART VII: DIVISION DECISION AND ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the Division has determined that the requestor is entitled to additional reimbursement in the amount of \$475.31.

Ordered by:

February 3, 2006

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Typed Name

\_\_\_\_\_  
Date of Order

**PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW**

Appeals of medical dispute resolution decisions and orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005]. An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. The Division is not considered a party to the appeal.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**