Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXAS HEALTH LLC

Respondent Name
HARTFORD INSURANCE COMPANY

MFDR Tracking Number
M4-12-2176-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
February 23, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The service was provided and the claim was denied per EOB precertification/authorization/notification absent. CPT code 90806 was preauthorized, #6279548. Please refer to the attached preauthorization letter for further reference."

Amount in Dispute: $140.59

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...based on the attached documentation from the psychologist the treatment was for ulnar neuropathy and cervical treatment which the attached CCH decision has adjudicated as not related to the compensable injury of [DOI]. No additional payments will be forthcoming based on the CCH decision which is now final."

Response Submitted by: Gallagher Bassett Service, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 18, 2009	90806	$140.59	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.600 sets out the Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care.
4. This request for medical fee dispute resolution was received by the Division on February 23, 2012.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   Explanation of benefits
   - 216 – Based on the findings of a review organization
   - 19 (197) – This line was included in the reconsideration of this previously reviewed bill.
   - LN – This line was included in the reconsideration of this previously reviewed bill.
   - 19 – Precertification/authorization/notification absent.

Issues

1. Did the insurance carrier submit documentation to support the issue of extent of injury raised in the position summary?
2. Did the requestor submit a copy of the preauthorization letter for review, with the DWC060 request?
3. Is the requestor entitled to reimbursement for CPT code 90806?

Findings

1. The insurance carrier indicated in the position summary that "the attached documentation from the psychologist the treatment was for ulnar neuropathy and cervical treatment which the attached CCH decision has adjudicated as not related to the compensable injury of [DOI]."

   To determine whether such an extent-of-injury or related dispute existed at the time any particular medical fee dispute was filed with the Division and whether it was related to the same service, the applicable former version of 28 Tex. Admin. Code § 133.240(e), (e) (1), (2) (C), and (g) addressed actions that the insurance carrier was required to take, during the medical bill review process, when the insurance carrier determined that the medical service was not related to the compensable injury: 31 TexReg 3544, 3558 (April 28, 2006). Those provisions, in pertinent parts, specified: Former 133.240(e), (e) (1), (2) (C), and (g): The insurance carrier shall send the explanation of benefits in the form and manner prescribed by the Division.... The explanation of benefits shall be sent to: (1) the health care provider when the insurance carrier makes payment or denies payment on a medical bill; and (2) the injured employee when payment is denied because the health care was: ... (C) unrelated to the compensable injury, in accordance with § 124.2 of this title... (g) An insurance carrier shall have filed, or shall concurrently file, the applicable notice required by Labor Code § 409.021, and § 124.2 and 124.3 of this title ... if the insurance carrier reduces or denies payment for health care provided based solely on the insurance carrier's belief that:. . (3) the condition for which the health care was provided was not related to the compensable injury.

   Review of the Explanation of Benefits does not indicate that the insurance carrier denied the disputed CPT code 90806 for extent of injury or that a related dispute existed at the time the medical dispute was filed with the division, as a result, the insurance carrier's issue is not supported and the disputed charges are subject to review pursuant to the applicable rules and guidelines.
2. 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 seeks reimbursement for CPT code 90806 defined by the AMA CPT Code Book as "Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient."

   The requestor references authorization #6279548, however did not submit a copy of the preauthorization letter for review with the DWC060 request. The division is therefore unable to determine if the disputed CPT code 90806 was included in the preauthorized services provided under authorization #6279548. As a result, reimbursement cannot be recommended for CPT code 90806.
3. The requestor has failed to support that the disputed service, CPT code 90806 was preauthorized, as a result the requestor is entitled to $0.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		July 10, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

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