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
INJURY 1 TREATMENT CENTER

Respondent Name
INDEMNITY INSURANCE CO

MFDR Tracking Number
M4-12-2298-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
March 6, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Treatment preauthorized per rule 134.600(a) treatment should be paid."

Amount in Dispute: $542.44

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on March 8, 2012. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 2, 2011, November 22, 2011 and November 30, 2011	90806 x 3	$406.83	$406.83
December 6, 2011	90806	$135.61	$0.00
TOTAL		$542.44	$406.83

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 §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
3. 28 Texas Administrative Code §134.600 sets out the procedure for Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 850-664 – No additional reimbursement allowed after review of appeal/reconsideration
   - 876 – Services disallowed per peer review $0.00
   - W9 – Services disallowed per peer review $0.00

Issues

1. Did the requestor obtain preauthorization for individual psychotherapy rendered November 2, 2011 through December 6, 2011?
2. Did the requestor bill in conflict with the NCCI edits?
3. Is the requestor entitled to reimbursement?

Findings

1. 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."

   Review of the submitted documentation supports that the requestor obtained preauthorization for 4 individual psychological sessions 1 x per week x 4 weeks with a begin date of 10/24/11 and an end date of 11/30/2011. The requestor seeks reimbursement for dates of service November 2, 2011, November 22, 2011, November 30, 2011 and December 6, 2011. The requestor obtained preauthorization for dates of service November 2, 2011, November 22, 2011 and November 30, 2011, therefore these dates will be reviewed pursuant to the applicable rules and guidelines.

   The requestor seeks reimbursement for CPT code 90806 rendered on December 6, 2011. The requestor submitted insufficient documentation to support that preauthorization was obtained for CPT code 90806 as required by 28 Texas Administrative Code §134.600 (p)(7). As a result, $0.00 is recommended for CPT code 90806 rendered on December 6, 2011.
2. Per 28 Texas Administrative Code §134.203 "(b) 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."

   The AMA CPT Code Book defines CPT code 90806 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 division completed NCCI edits to identify potential NCCI edit conflicts that would affect reimbursement. The requestor billed CPT codes 90806 and 90889 for each disputed date of service. The following was identified:

   Payment for Procedure Code 90889 is always bundled into payment for other services not specified and no separate payment is made, per Medicare. The requestor seeks reimbursement for CPT code 90806 with no identified NCCI edit conflicts. The requestor is therefore entitled to reimbursement pursuant to 28 Texas Administrative Code §134.203 (c).
3. Per 28 Texas Administrative Code §134.203 "(c) 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."

   Per 28 Texas Administrative Code §134.203 "(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 MAR reimbursement for CPT code 90806 is $141.03 x 3 = $423.09. The requestor seeks reimbursement in the amount of $135.61 x 3 = $406.83, therefore this amount is recommended for dates of service November 2, 2011, November 22, 2011 and November 30, 2011.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $406.83.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $406.83 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		August 1, 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.