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
HEALTHTRUST

Respondent Name
NATIONAL AMERICAN INSURANCE CO

MFDR Tracking Number
M4-12-2390-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
MARCH 19, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier originally denied the bill because the provider, Veronica Barajas, is an unlicensed provider and required a supervisor, James Flowers PhD, to sign off on her notes. The original bill had Dr. Flowers' information in the billing section because he signed off on her report. HealthTrust then sent the carrier a reconsideration letter explaining this information to try and resolve the issue. The carrier is now denying the claim because they say that a 'supervising MD can only bill for unlicensed HCP. This provider is licensed & must bill own services'. This is completely contradictory to what the first EOB stated. Veronica Barajas saw the patient and wrote the initial report. Ms. Barajas is a Licensed Professional Counselor – Intern. This is why Dr. Flowers, PhD signed off on her report and reviewing it. HealthTrust billed under his license number because Ms. Barajas does not have her own license number yet."

Amount in Dispute: $741.42

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "'**Dr. Flowers is the clinical supervisor of Ms. Veronica Barajas, a Licensed Professional Counselor – Intern' See Exhibit 1**. In this exhibit, the provider admits that Ms. Barajas is licensed, therefore the billing should be in her name. Rule 133.20(d)(2) clearly states 'The health care that provided the health care shall submit its own bill, unless: (2) the health care was provided by an **unlicensed** individual under the direct supervision of a licensed health care provider, in which case the supervising health care provider shall submit the bill;' By the HCP's own admission, Ms. Barajas was/is licensed in Texas as MDs/DOs and their bills are submitted as the rendering provider. This letter also states that **'Dr. Flowers is present during the patient evaluation and assited with the report writing, he will sign off on her report and will be placed on the HCFA'**. As you can see from Exhibit 2, attached, Dr. Flower's signature is NOT on the documentation. While his name is listed, the fact that Ms. Barajas signed the documentation indicates she is the rendering provider. Had Dr. Flowers signed the report in addition to Ms. Barajas, then payment would've been allowed, but that is not the case as is evidenced by the document in Exhibit 2…As such it is Corvel's stance that since the HCP failed to comply with rule 133.20(e)(2) and rule 133.10(f)(1)(Z), no reimbursement will be recommended at this time."

Response Submitted by: Corvel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 14, 2011	CPT Code 90801 Psychiatric Diagnostic Interview Examination	$741.42	$241.65

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, effective March 1, 2008, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system.
3. 28 Texas Administrative Code §133.20, effective January 29, 2009, sets out the rule for medical bill submission by a Health Care Provider.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - B20-Srvc partially/fully furnished by another provider
   - 193-Original payment decision maintained.

Issues

1. Was the submitted billing submitted in accordance with 28 Texas Administrative Code §133.20?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.20(e)(2) states "A medical bill must be submitted: in the name of the licensed health care provider that provided the health care or that provided direct supervision of an unlicensed individual who provided the health care."

   The respondent maintains the denial of reimbursement based upon "the HCP failed to comply with rule 133.20(e)(2) and rule 133.10(f)(1)(Z)."

   The requestor contends that reimbursement is due because "Ms. Barajas is a Licensed Professional Counselor – Intern. This is why Dr. Flowers, PhD signed off on her report and reviewing it. HealthTrust billed under his license number because Ms. Barajas does not have her own license number yet."

   The Division reviewed the submitted documentation and finds the following:

   - James S. Flowers PhD is listed in box 31 of the medical bill.
   - The Evaluation report is signed by Veronica M. Barajas, MA, LPC-I; however, Dr. Flowers is also listed on the signature page.
   - A LPC-I is a Licensed Professional Counselor Intern.

   The Division concludes that per 28 Texas Administrative Code §133.20(e)(2), Ms. Barajas was an intern and required supervision. Because she was an intern she had not obtained her professional license; therefore, the requestor billed in accordance with 28 Texas Administrative Code §133.20(e)(2).

2. CPT Code 90801 is defined as "Psychiatric Diagnostic Interview Examination." Per the American Medical Association, "Psychiatric diagnostic interview examination includes a history, mental status, and a disposition, and may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies. In certain circumstances other informants will be seen in lieu of the patient." Per the code descriptor, this is not a timed procedure or service.

   Per 28 Texas Administrative Code §134.203(c) (1) (2), "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. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division

conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

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

The 2011 DWC conversion factor for this service is 54.54.

The Medicare Conversion Factor is 33.9764.

The Medicare Participating Amount is $150.54.

Review of Box 32 on the CMS-1500 the services were rendered in El Paso, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for "Rest of Texas".

Using the above formula the MAR is $241.65. The respondent paid $0.00. As a result, the requestor is due $241.65.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $241.65.

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 $241.65 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		08/08/2014
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.