TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
BODIES IN BALANCE

Respondent Name
ASSOCIATION CASUALTY INSURANCE

MFDR Tracking Number
M4-12-2834-02

Carrier's Austin Representative
Box Number 53

MFDR Date Received
May 4, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We received this correspondence from the insurance company attaching copy of the designated doctor dated 08/01/11 diagnosis... Bills were preauthorized auth# 108867F0, billed with diagnosis... which is part of the..., bills were properly approved and billed, before DD report."

Amount in Dispute: $1,410.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Enclosed please find the peer review regarding this Claimant authored by John Ombermiller, M.D. who opined on 05-12-11 that additional physical therapy was not supported by sound evidence-based medicine. Also enclosed is the report from designated doctor David Gilbert, D.O., who opined on 08-01-11 that the compensable injury is limited..."

Response Submitted by: Hoffman Kelley

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
June 21, 2011 through July 18, 2011	99801, 99214 x 2 and 90806 x 6	$1,410.00	$720.00

FINDINGS AND DECISION

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

Background

1. Former 28 Texas Administrative Code §133.305 sets out the general Medical Dispute Resolution guidelines.
2. Former 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. Former 28 Texas Administrative Code §133.308 sets out the procedure for Medical Dispute Resolution of Medical Necessity Disputes.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - W9 – Unnecessary medical treatment based on peer review
   - 216 – Based on the findings of a review organization
   - O – Denial after reconsideration
   - Note: Unnecessary medical treatment based on peer review

Issues

1. Does the medical fee dispute referenced above contain information/documentation that indicates that there are **unresolved** issues of medical necessity?
2. Is the insurance carrier's denial of unnecessary medical supported for CPT Code 90806?
3. Is the requestor entitled to reimbursement for CPT Code 90806?

Findings

1. The requestor seeks reimbursement for CPT Code(s) 99801 and 99214 x 2 rendered on June 21, 2011, June 24, 2011 and July 18, 2011. The insurance carrier denied/reduced the disputed services with denial/reduction code(s):

   - W9 – Unnecessary medical treatment based on peer review
   - 216 – Based on the findings of a review organization
   - Note: Unnecessary medical treatment based on peer review

   Review of the submitted documentation finds that the medical fee dispute referenced above contains information/ documentation to support that the disputed services contain **unresolved** issues of medical necessity for the same service(s) for which there is a medical fee dispute. The insurance carrier notified the requestor of such issues in its explanation of benefits (EOB) response(s) during the medical bill review process.

   28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding…medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding…medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021.

   The Division hereby notifies the requestor the appropriate process for resolution of an unresolved issue of medical necessity requires filing for an independent review to be conducted by an IRO (independent review organization) appropriately licensed by the Texas Department of Insurance, pursuant to 28 Texas Administrative Code §133.308. Information applicable to HEALTH CARE PROVIDERS on how to file for an IRO may be found at http://www.tdi.texas.gov/hmo/iro_requests.html under ***Health Care Providers or their authorized representatives***.

   The Division finds that due to the unresolved medical necessity issues, the medical fee dispute request for CPT Code(s) 99801 and 99214 x 2 rendered on June 21, 2011, June 24, 2011 and July 18, 2011 are not eligible for review until a final decision has been issued in accordance with 28 Texas Administrative Code §133.308.

2. The requestor seeks reimbursement for CPT Code 90806 rendered on June 30, 2011 through July 18, 2011. The insurance carrier denied the disputed services with denial/reduction code(s):

   - W9 – Unnecessary medical treatment based on peer review
   - 216 – Based on the findings of a review organization
   - Note: Unnecessary medical treatment based on peer review

   Review of the preauthorization letter dated June 23, 2011 issued by FORTE, indicates the following:

Authorization for requested services – Dated June 23, 2011	
Services Requested	Outpatient individual psych x 6 (2x3) sessions...
Outcome	The requesting provider has represented to Forte that the authorized services will be initiated within the next 30 days and this representation was a material factor in our determination that the services were medically necessary.
Forte Recommendation	Certification
Your authorization number is	1088067 F O

   The Division finds that the insurance carrier preauthorized the disputed CPT Code 90806. Section 413.014 titled PREAUTHORIZATION REQUIREMENTS; CONCURRENT REVIEW AND CERTIFICATION OF HEALTH CARE (e) states in pertinent part, "If a specified health care treatment or service is preauthorized as provided by this section, that treatment or service is not subject to retrospective review of the medical necessity of the treatment or service."

   The Division therefore finds that the insurance carrier's denial reason(s) are not supported and therefore, the requestor is entitled to reimbursement for the disputed service.

Per 28 Texas Administrative Code §134.600 (c) (1) (B) states in pertinent part, "(c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur... (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care..."

3. The requestor seeks reimbursement for CPT Code 90806 rendered on June 30, 2011 through July 18, 2011. Per 28 Texas Administrative Code §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 90806 is defined 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."

   Per 28 Texas Administrative Code §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..."

   The MAR for CPT Code 90806 is $144.69 x 6 = $868.15. The requestor seeks $120.00 x 6 = $720.00.

   28 Texas Administrative Code §134.303 (c) (e) states, "In all cases, reimbursement shall be the lesser of the: (1) MAR amount; (2) health care provider's usual and customary charge; or (3) workers' compensation negotiated and/or contracted amount that applies to the billed service(s). As a result, the requestor is entitled to a total reimbursement amount of $720.00. As a result, this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due for CPT Code 90806 x 6 rendered on June 30, 2011 through July 18, 2011 . As a result, the amount ordered is $720.00.

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 $720.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		May 9, 2019
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 in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim. The party seeking review of the MFDR decision shall deliver a copy of the request 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 §141.1(d).

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