



MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address: Texas Health P.O. Box 600324 Dallas, TX 75360	MDR Tracking No.: M4-05-7918-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: American Home Assurance Co. C/o Flahive, Ogden & Latson Box 19	Date of Injury:
	Employer's Name: Wal Mart Stores, Inc.
	Insurance Carrier's No.: C4200583

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Requestor's position summary states in part, "...CPT code 90806 was pre-authorized and was provided as a separate procedure for the date of service listed. This charge should be paid according to the TWCC Medical Fee Guideline... CPT code 90880 does not require pre-authorization per TWCC Rule 134.600. The Fee Guideline for this code is \$157.71 per unit...CPT code 90889 refers to the report charge. Every report submitted to the insurance carrier has to be written by the provider of the service... This takes time and effort and should be reimbursed at a fair and reasonable rate... Procedures that are performed on the same day, but at a different time period are allowed by TWCC Guidelines **because** they are performed mutually exclusive of each other..."

Principle Documentation:

1. Requestor's position summary
2. HCFA 1500's
3. EOB's

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Respondent's position summary states in part, "...I am filing the TWCC-60 on behalf of the above-referenced insurance carrier in response to the Requestor's dispute regarding fee reimbursement for dates of service May 3, 2004 through June 24, 2004 in the amount of \$720.00. As a result, further payment in the amount of \$124.80 was recommended towards the disputed amount. Please refer to the attached re-evaluation and explanation of benefits reports..."

Principle Documentation:

1. Respondent's position summary
2. EOBs

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
05/03/04	90806	1	\$124.80
05/10/04	90880	2	\$32.91
06/24/04	90806	3	\$0.00
05/03/04 – 06/24/04	90889 (3)	4	\$0.00
TOTAL DUE			\$157.71

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, sets out reimbursement guidelines.

This dispute relates to procedures 90806 (psychotherapy), 90880 (hypnotherapy) and 90899 (report preparation). The basis of the denials were: **Date of service 05/03/04** – "G - Unbundling (code 90889) and Z – Preauthorization requested by denied (code 90806).

The carrier received date was 03/04/05 and the re-evaluation EOB of 04/14/05 denied as "This claim is now being denied for untimely submission. Per Rule 134.801(c), the provider has the 1st day of the 11 month following date of treatment/services..." The date of the original review as noted on the re-evaluation EOB was 03/14/05. An EOB with a post date of 03/14/05 denies CPT Code 90806 as "Z – Preauthorization requested by denied". **Date of service 05/10/04** – Initial EOB denied the services at "R – Charge unrelated to compensable injury", upon reconsideration the disputed codes of 90880 and 90889 were denied as "45 – Charges exceed your contracted/legislated fee arrangement; 730 – reduction or denial of payment resulting after a reconsideration was completed; and 717 – the value of this procedure is included in the value of another procedure performed on this date. **Date of service 06/24/04** – Initial EOB denied the services as "R – Charge unrelated to compensable injury", upon a re-evaluation on 5/24/05 the disputed code of 90806 was paid; code 90889 was denied as "717 – The value of this procedure is included in the value of another procedure performed on this date" on 05/24/05.

1. CPT Code 90806 for date of service 05/03/04 – Preauthorization was obtained for this CPT code on 4/29/04; therefore, preauthorization is not an issue. According to the EOBs submitted by the Carrier the date of the original review was 03/14/05, in calculating the 1st day of the 11th month the original review was done in the 10th month. Therefore, the Carrier has incorrectly denied payment for CPT Code 90806. The submitted psychotherapy note supports services were rendered. Reimbursement in the amount of \$124.80 is recommended.
2. CPT Code 90880 for date of service 05/10/04 – According to Medicare Correct Coding Initiative (CCI) Edits CPT Code 80806 is a component procedure of CPT Code 90880. The Carrier paid \$124.80 for CPT Code 90806, which according to the Medicare Fee Schedule plus 125% is the correct payment; the correct payment for CPT Code 90880 is \$157.71; therefore, additional reimbursement in the amount of \$32.91 (\$157.71 - \$124.80) is recommended.
3. CPT Code 90806 for date of service 06/24/04 was paid by the Carrier as noted in the re-evaluation EOB of 05/24/05; therefore, no additional reimbursement can be recommended.
4. CPT Code 90889 for dates of service 05/03/04, 05/10/04 and 06/24/04. According to Medicare this code is considered a part of the psych services and not payable. Therefore, reimbursement is not recommended.

Therefore it is the conclusion of the Medical Review Division that additional reimbursement in the amount of \$157.71 is due the requestor.

28 Texas Administrative Code Sec. 413.011(a-d)
28 Texas Administrative Code Sec. 134.202
28 Texas Administrative Code Sec. 134.600(h)(4)

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 **\$157.71**. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30-days of receipt of this Order.

Ordered by:

Marguerite Foster

January 5, 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.