Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 ● Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Glenn J. Bricken, Psy.D. 25810 Oakridge Drive The Woodlands, Texas 77380	MDR Tracking #. M4-07-3870-01 Claim #: Injured :
Respondent's Name and Box #: Alief I.S.D. c/o Harris & Harris Box #42	Date of Injury: Employer's Name: . Insurance Carrier's #: ALF23002

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary states in part, "90801 is a timed procedure" "90885, 90887, and 99080 are not global/bundled to 90801" "…the TDI/DWC fee schedule is not at [sic] carbon copy of Medicare's, it is rather a modified version thereof. While Medicare will only reimburse one unit of the 90801, this is not the case under Worker's Compensation guidelines per Division rule §134.202(c) (1)…While this passage gives some correlation to Medicare regarding the RATE of reimbursement, it does not speak to the QUANTITY or number of services to be performed." By asserting that both the 90885, the 90887, and the 90889 were to be included with another service, the carrier is attempting to deny the claims under the auspices of "unbundling," this is not applicable due to the fact that each is a distinct procedure. The services provided were not unbundled."

Principle Documentation:
1. DWC 60 package
2. CMS 1500's
3. Medical Reports
4. Explanation of Benefits

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary states in part, "90801 is not a timed procedure" "90885, 90887, and 99080 are bundled to 90801" "DWC Healthcare Technical Update Issue No.3 February 2006, The diagnostic psychiatric interview CPT code 90801 is reimbursed under the 2002 MFG as a single unit regardless of the amount of time spent on a diagnostic interview." "90885 is a status "B" "Bundled" code and service is not paid separately." "90887 is a status "B" "Bundled" code and service is not paid separately." "T.D.I./D.W.C. 134.120(g), Narrative reports are defined as original documents explaining the assessment, diagnosis , and plan of treatment for an injured employee written or orally transcribed and created at the written request of the insurance carrier or the Division. The report was neither requested nor require by the insurance company."

Principle Documentation:
1. DWC 60 package

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	Denial Code	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
03/09/2006	F	90801	4	$0.00
03/09/2006	N,G	90885	5	$0.00
03/09/2006	N,G	90887	6	$0.00
03/09/2006	G	99080	7	$0.00
TOTAL DUE				$0.00

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Section 413.011(a-d) titled *Guidelines and Medical Policies*, and Division Rule 134.202 titled *Medical Fee Guideline* effective August 1, 2003, sets out reimbursement guidelines.

1. This dispute relates to procedures/services that were billed under CPT codes 90801, 90885, 90887, 99080 for DOS 03/09/2006.

2. Per Rule 133.307(d), the request for medical dispute resolution was received in the Division on 02/27/2007.

3. Based on Division Rule 133.307(d) (1-2), the date of service eligible for review is 03/09/2006.

4. CPT code 90801 is defined as psychiatric diagnostic interview examination, which includes taking the patient's history and assessing his/her mental status, as well as disposition. The psychiatrist may spend time communicating with family, friends, co-workers, or other sources as part of this examination and may even perform the diagnostic interview on the patient entirely through other informative sources. Laboratory or other medical studies and their interpretation are also included. The Respondent denied reimbursement based upon "F—D.W.C Technical Update Issue No. 3, February 2006. "The diagnostic psychiatric interview CPT code 90801 is reimbursed under the 2002 MFG as a single unit regardless of the amount of time spent on a diagnostic diagnostic [sic] interview."" Upon request for reconsideration reimbursement was again denied based upon "F—D.W.C Technical Update Issue No. 3 February 2006. "The diagnostic psychiatric interview CPT code 90801 is reimbursed under the 2002 MFG as a single unit regardless of the amount of time spent on a diagnostic diagnostic [sic] interview.""

Per the CMS-1500, the zip code is 77380 which is located in Montgomery County. This is not a timed procedure. Per rule 134.202 the MFG MAR for CPT code 90801 in Montgomery County is $183.81. Per check #56436 issues on 5/19/2006, the Respondent paid $183.81; therefore, additional reimbursement is not recommended.

5. CPT code 90885 is defined as psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes. The Respondent denied reimbursement based upon "N—Not appropriately documented." And "G-- D.W.C. Healthcare Technical Update Issue No. 3. February 2006, "According to the Medicare Physician Fee Schedule Data Base, CPT codes with a "B" status code are bundled codes. This means that these codes are not reimbursed separately. For example 90885 and 90889 are bundled codes for preparation or review of medical diagnostic reports prepared for physicians, agencies or insurance carriers." Upon request for reconsideration, reimbursement was again denied based upon "N—Not appropriately documented." And "G-- D.W.C. Healthcare Technical Update Issue No. 3. February 2006, "According to the Medicare Physician Fee Schedule Data Base, CPT codes with a "B" status code are bundled codes. This means that these codes are not reimbursed separately. For example 90885 and 90889 are bundled codes for preparation or review of medical diagnostic reports prepared for physicians, agencies or insurance carriers." Per Rule 134.202(b) this is bundled to CPT code 90801 billed on the same DOS and is not reimbursable.

6. CPT code 90887 is defined as interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient. The Respondent denied reimbursement based upon "N—Not appropriately documented." And "G-- 90887 is "Interpretation or explanation of results of psychiatric, other medical examinations and procedures or

other accumulated to family or other responsible persons, or advising them how to assist patient". Upon request for reconsideration, reimbursement was again denied based upon "N—Not appropriately documented." And "G--90887 is "Interpretation or explanation of results of psychiatric, other medical examinations and procedures or other accumulated to family or other responsible persons, or advising them how to assist patient". Documentation attached to the bill does not support this code." Per Rule 134.202(b), this is bundled to CPT code 90801 billed on the same DOS and therefore is not reimbursable.

7. CPT code 99080 is defined as special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form. The insurance carrier denied reimbursement based upon "G—Local Coverage Determination V-6.5 requires for description 90801, "Consultation services require, in addition to the interview and examination, providing a written opinion or advice."" Per Rule 134.202, narrative reports are not global and may be reimbursed. A review of the CMS-1500 indicates that the Requestor utilized modifier "N-4"; this modifier is not contained in Rule 134.202. A narrative report is defined in Rule 133.106(e) as "…original documents explaining the assessment, diagnosis, and plan of treatment for an injured employee written or orally transcribed. Narrative reports shall provide information beyond that required by prescribed report forms. The narrative reports should be no more than double-spaced on letter size paper. Clinical or progress notes do not constitute a narrative report." The Respondent denied reimbursement based upon "G—Consultation services require, in addition to the interview and examination, providing a written opinion or advice." Upon request for reconsideration, reimbursement was again denied based upon "G—Consultation services require, in addition to the interview and examination, providing a written opinion or advice." The Requestor submitted the Psychological Evaluation report to support billing. The report of the psychological evaluation is global to that service. The Requestor did not submit a separate narrative report to support billing; therefore, no reimbursement is recommended.

Therefore it is the conclusion of the Medical Dispute Resolution that additional reimbursement is not due the Requestor.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 413.011(a-d)
28 Texas Administrative Code Sec. §133.307, §134.1and §134.202

PART VII: DIVISION DECISION

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 not entitled to additional reimbursement.

Decision by:

		05/22/2007
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

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.