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 Oak Ridge Drive The Woodlands, Texas 77380	MDR Tracking #.: M4-07-4580-01 Claim #: Injured Employee:
Respondent's Name and Box #: Lowes Home Centers Inc. c/o Downs Stanford Box #17	Date of Injury: Employer's Name: Lowes Home Centers Inc. Insurance Carrier's #: CFB13377 C

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary states in part, "Services provided do not require preauthorization per D.W.C. rule 134.600(p)…" "There is no requirement under applicable TDI/DWC rules that mandates preauthorization for these services. Division Rule §134.600(p) outlines all non-emergency procedures that require preauthorization…90801, 90885, 90887, and 99080 are all absent."

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 "…psychotherapy was not preauthorized in accordance with D.W.C. rule [sic] 134.600. Therefore, the evaluation and all other tasks performed in conjunction with that task have been denied."

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)
04/04/2006	62,850	90801	1-4	$180.00
04/04/2006	62,250	90885	1,2,3,5	$0.00
04/04/2006	62,250	90887	1,2,3,6	$0.00
04/04/2006	62,250	99080	1,2,3,7	$0.00
TOTAL DUE				$180.00

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 04/04/2006.

2. Per Rule 133.307(d), the request for medical dispute resolution was received in the Division on 03/26/2007.

3. Based on Division Rule 133.307(d) (1-2), the only date of service eligible for review is 04/04/2006.

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 on "62—Payment denied/reduced for absence of, or exceeded, pre-certification/authorization." and "850—Services rendered appear to be un-authorized prior to treatment." Upon request for reconsideration, services were again denied reimbursement based on "62—Payment denied/reduced for absence of, or exceeded, pre-certification/authorization." and "850—Services rendered appear to be un-authorized prior to treatment."

Preauthorization is not required by Rule 134.600 for CPT code 90801 for the initial examination. Per the CMS-1500, the zip code is 77380 which is located in Montgomery County. The MFG MAR for CPT code 90801 in Montgomery County is $183.81. This is not a timed procedure. The Requestor billed $180.00. The Respondent paid $0.00; therefore, reimbursement of $180.00 is recommended per Rule 134.202(d)(2).

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 insurance Respondent reimbursement based upon "62—Payment denied/reduced for absence of, or exceeded, pre-certification/authorization." and "850—Services rendered appear to be un-authorized prior to treatment." Upon request for reconsideration, services were again denied based upon "62—Payment denied/reduced for absence of, or exceeded, pre-certification/authorization." and "850—Services rendered appear to be un-authorized prior to treatment." Per Rule 134.202(b) this is bundled to CPT code 90801 billed on this same DOS and therefore 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 "62—Payment denied/reduced for absence of, or exceeded, pre-certification/authorization." and "850—Services rendered appear to be un-authorized prior to treatment." Upon request for reconsideration, services were again denied based upon "62—Payment denied/reduced for absence of, or exceeded, pre-certification/authorization." and "850—Services rendered appear to be un-authorized prior to treatment." Per Rule 134.202(b) this is bundled to CPT code 90801 billed on this 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 Respondent denied reimbursement based upon "62—Payment denied/reduced for absence of, or exceeded, pre-certification/authorization." and "850—Services rendered appear to be un-authorized prior to treatment." Upon request for reconsideration, services were again denied based upon "62—Payment denied/reduced for absence of, or exceeded, pre-certification/authorization." and "850—Services rendered appear to be un-authorized prior to treatment." 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 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 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, §134.1, §134.106, §134.202 and §134.600

PART VII: DIVISION DECISION AND/OR 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 reimbursement. Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $180.00 plus accrued interest, due within 30 days of receipt of this Order.

Ordered 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.