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 and Address

TX HEALTH DBA INJURY 1 OF DALLAS
9330 LBJ FREEWAY SUITE 1000
DALLAS TX 75243

Respondent Name
Chartis Casualty Co

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-14-0221-01

MFDR Date Received
September 23, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim was paid incorrectly. CPT Code 90791 was not paid and denied per EOB this procedure code has not been adopted by the state. CPT code 90791 is the correct and new 2013 code…"

Amount in Dispute: $1,052.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgement of medical fee dispute sent to respondent however, no response submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 4, 2013	Professional Services	$1,052.30	$246.79

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 a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out requirements for medical bill submission by health care providers.
3. 28 Texas Administrative Code §133.203 sets out medical bill submission requirements for health care providers.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 1 – This contracted provider or hospital has agreed to reduce this charge below fee schedule or usual and customary charges for your business.
   - 2 – Any reduction is in accordance with a Coventry owned contract.
   - 3 – Procedure code is not valid for this date of service
   - This procedure code has not been adopted by the state.

Issues

1. Did the requestor submit the medical bill in compliance with Division guidelines?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed service as, 3 – "Procedure code is not valid for this date of service". 28 Texas Administrative Code §133.20(b)(1) 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; …and other payment policies in effect on the date a service is provided…" The medical bill for the service in dispute included code 90791, "Psychiatric diagnostic evaluation. A psychiatric diagnostic evaluation is performed, which includes the assessment of the patient's psychosocial history, current mental status, review and ordering of diagnostic studies followed by appropriate treatment recommendations. Effective date of this code was 01/01/2013. The date of service in dispute is 03/04/13. The carrier's denial is not supported. Therefore, the service in dispute will be reviewed per applicable rules and fee guidelines.
2. 28 Texas Administrative Code §133.203(c) is the applicable division fee schedule for calculation of the maximum allowable reimbursement for the services in dispute. For services in 2013, the maximum allowable reimbursement = (TDI-DWC Conversion Factor / Medicare CONV FACT) x Non-Facility Price or: (55.3 / 34.023) x 151.84 = $246.79 for one unit. Medical bill reflects 5 units however; the submitted code is not subject to time increments therefore, one unit is supported.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $246.79.

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 $246.79 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		March 3, 2014
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, effective May 31, 2012, *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 MDR 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.