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
New Hampshire Insurance Co

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-14-0901-01

MFDR Date Received
November 19, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "… it is our position that Chartis Insurance has established an unfair and unreasonable time frame in paying for the services that were medically necessary and rendered…"

Amount in Dispute: $1,052.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "… it is the carrier's position that the bill was denied correctly because the provider did not bill correctly. CPT 90791 is not a timed code. CPT 90791 is a diagnostic evaluation. There is no documentation to support their billing in units. CPT 2013 description is diagnostic assessment and any psychotherapeutic services should be billed in addition. Additionally, CPT Codes 90882, 90885 and 90889 are bundles per Medicare rules and Texas has always upheld those bundles also."

Response Submitted by: AIG, P.O. Box 25794, Shawnee Mission, KS 66225

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 7, 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 §134.203, sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - D19 – Claim/Service lacks Physician/Operative or other supporting documentation

- Invalid number of units
- 96 – Non-covered charge(s)
- Our position remains the same if you disagree with our decision please contact the division for medical fee dispute resolution (MFDR)

Issues

1. Did the requestor submit disputed services in compliance with Division rules?
2. Did the respondent support denial of the disputed service?
3. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §133.20(c) states in pertinent part, "A health care provider shall include correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitting medical bills. Review of the submitted documentation finds the submitted code of 90791. The CPT Code detail for this code states, "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." Review of the submitted medical records finds the following;
    - History of presenting problem and resulting treatment
    - Present medications
    - Patient's description of pain
    - Medical & psychiatric history
    - Social, educational and vocational histories
    - Lifestyle changes related to the injury
    - Mental status exam/clinical observation/psrs
    - Multiaxial diagnosis
    - Secondary problem areas identified that are impacting his recovery include
    - Treatment recommendations/summary

    The Division finds the medical record does support the submitted code however; the number of units cannot be supported as there is no increment of time listed within description of submitted code. Therefore, only one unit of service can be allowed.
2. The carrier denied the disputed service as, D19 "Claim/Service lacks Physician/Operative or other supporting documentation". Review of the medical record finds the submitted code, 90791, is supported by the medical record as described above. Therefore, this service will be reviewed per applicable rules and fee guidelines.
3. 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:
    - Procedure code 90791, service date May 7, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 2.8 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 2.8252. The practice expense (PE) RVU of 1.52 multiplied by the PE GPCI of 1.017 is 1.54584. The malpractice RVU of 0.11 multiplied by the malpractice GPCI of 0.834 is 0.09174. The sum of 4.46278 is multiplied by the Division conversion factor of $55.30 for a MAR of $246.79.
    - Procedure code 90889, service date May 7, 2013, has a status indicator of B, which denotes a bundled code. Payments for these services are always bundled into payment for other services to which they are incident.

    The total allowable reimbursement for the services in dispute is $246.79. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $246.79. This amount is recommended.

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.