



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

ULTIMATE PAIN SOLUTIONS

Respondent Name

ALIEF ISD

MFDR Tracking Number

M4-16-1873-01

Carrier's Austin Representative

Box Number 21

MFDR Date Received

MARCH 4, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am submitting my bills with the following information showing that we have gotten preauthorization of the medical treatment that was provided."

Amount in Dispute: \$1,350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent has utilized the mandated Medical Fee Guidelines and 504.053 and has made reimbursement in accordance with same."

Response Submitted by: Thronton, Biechlin Reynolds & Guerra

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 25, 2015	CPT Code 90791 (X3) Psychiatric diagnostic evaluation	\$1,350.00	\$0.00

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.600, effective July 1, 2012, requires preauthorization for specific treatments and services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 16-Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.

Issues

Does the documentation support billing code 90791(X3)? Is the requestor entitled to reimbursement?

Findings

According to the explanation of benefits, the respondent denied reimbursement for the disputed services based upon a lack of documentation.

28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

28 Texas Administrative Code §134.203 (b)(1) states "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; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

CPT code 90791 is defined as "Psychiatric diagnostic evaluation."

A review of the submitted billing finds that the requestor billed for three units of code 90791. The requestor did not submit any medical documentation to support billing code 90791(X3). As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

		05/13/2016
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.