TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
HEALTHCARE REHAB GROUP

Respondent Name
INSURANCE COMPANY OF THE STATE OF PENNSYLVANIA

MFDR Tracking Number
M4-16-3071-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 9, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "note clearly states that he 'talked' with him, indicating that services were documented and furnished to the patient."

Amount in Dispute: $207.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "we have escalated the bills in question fro manual review to determine if additional monies are owed."

Response Submitted by: Gallagher Bassett Services, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 14, 2016	Psychotherapy, procedure code 90837	$207.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 11 – "(112) SERVICE NOT FURNISHED DIRECTLY TO THE PATIENT AND/OR NOT DOCUMENTED."

   28 Texas Administrative Code §133.307(c)(2)(M) requires that the requestor shall provide with the request for MFDR a copy of all applicable medical records related to the dates of service in dispute. This decision is based on the information provided by the requestor at the time of review.

   Review of the submitted information finds that procedure code 90837 represents psychotherapy, 60 minutes with patient or family member—a timed service, requiring at least 53 minutes spent face-to-face with the patient and/or a family member, not including additional evaluation and management services.

   Review of the submitted medical record finds that start and stop times are not documented, nor is there any notation of total time spent face-to-face with the patient performing this individual service.

   Further, the office note has a pre-printed check-box containing procedure codes and unit increments for the provider to mark as an indication of which service and how many units had been performed; however, the submitted document does not have a check mark next to any of the listed services nor any indication of the number of units or minutes performed. The Division concludes that the submitted documentation fails to support the services as billed.

   The insurance carrier's denial reason is supported. Additional reimbursement cannot be 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 on 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 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	August 5, 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, 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 MFDR 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.