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
Gabriel Jasso, PHD

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-17-3780-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
August 22, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134."

Amount in Dispute: $214.70

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed 2 units of code 90791. The 2017 CPT manual indicates the code may be reported more than one per patient when a separate evaluation with an informant is performed. Texas Mutual reviewed the billing and attached documentation, and concluded only one unit of 90791 is documented. Thus only one unit was allowed per date of service. Review of the DWC60 packet demonstrates documentation for one unit. No reference is made in the evaluation of another informant evaluation. No additional payment is due."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 14, 2017	90791	$214.70	$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 reimbursement guidelines for professional medical

services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 151 – Payment adjusted because the payer deems the information submitted does not support this many/frequency of services
   - 298 – Only one is allowed per date of service
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
   - W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
   - 724 – No additional payment after a reconsideration of services

Issues

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

Findings

1. The requestor is seeking reimbursement for a second unit of code 90791 – "Psychiatric diagnostic evaluation" for date of service April 14, 2017. The insurance carrier denied disputed services with claim adjustment reason code 151 – "Payment adjusted because the payer deems the information submitted does not support this many/frequency of services" and 298 – "Only one is allowed per date of service."

   28 Texas Administrative Code §134.203 (c) states,

   > 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

   The billed code 90791 is not a timed code. The 2017 American Medical Association CPT Code book states, "Codes 90791, 90792 may be reported more than once for the patient when separate diagnostic evaluations are conducted with the patient and other informants." Review of the "Psychological Examination" report included with the request for MFDR indicates only the injured worker was interviewed. Insufficient evidence was found to support a second unit of service was performed on this date of service.

   Therefore, the carrier's denial is supported and no additional payment is 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 submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		September 13, 2017
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 Rule §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 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. **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.