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 Ph.D.

Respondent Name
Metropolitan Transit Authority Harris Co

MFDR Tracking Number
M4-19-2390-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 31, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The narrative report supports the number of itemized units on the HCFA 1500."

Amount in Dispute: $224.96

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…the report submitted by the provider does not support a separate diagnostic evaluation with anyone else other than the claimant to support billing the two units of code 90791. Moreover, that code is not defined as a timed procedure."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 5, 2018	90791	$224.96	$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 of 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 services
   - P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

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

Findings

1. The requestor is seeking $224.96 for code 90791 – "Psychiatric diagnostic evaluation." The insurance carrier reduced the number of services allowed to one with claim adjustment reason code 151 – "Payment adjusted because the payer deems the information submitted does not support this many services.

   28 Texas Administrative Code §134.203 (b) 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;

   The respondent states in their position, "...the report submitted by the provider does not support a separate diagnostic evaluation with anyone else other than the claimant to support billing the two units…"

   The submitted "Psychological Examination" dated October 5, 2018 indicates the total time, however based on the code description shown above, this is not a timed code. The carrier's reduction is supported.

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

		January 25, 2018
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.