



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Nueva Vida Behavioral Health

**Respondent Name**

Old Republic Insurance Co

**MFDR Tracking Number**

M4-24-0099-01

**Carrier's Austin Representative**

Box Number 44

**DWC Date Received**

September 13, 2023

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 24, 2023	90837	\$200.00	\$0.00
March 31, 2023	90837	\$200.00	\$0.00
April 7, 2023	90837	\$200.00	\$0.00
<b>Total</b>		\$600.00	\$0.00

### Requestor's Position

The requestor did not submit a position statement with this request for Medical Fee Dispute Resolution (MFDR). The did submit a copy of their reconsideration that states, "This date of service was performed within the authorized timeframe and was denied in error. Denying preauthorized health care services is an administrative violation in accordance with Rule 133.301(a). I have attached the original claim, Explanation of Benefits, treatment progress note, and the preauthorization letter for your review.'

**Amount in Dispute:** \$600.00

### Respondent's Position

The Austin carrier representative for Old Republic Insurance Co is White Espey PLLC. The

representative was notified of this medical fee dispute on September 19, 2023.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

**Response submitted by:** N/A

## **Findings and Decision**

### Authority

This medical fee dispute is decided according to [Texas Labor Code §413.031](#) and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

### Statutes and Rules

1. [28 Texas Administrative Code \(TAC\) §133.307](#) sets out the procedures for resolving medical fee disputes.
2. [28 TAC §134.203](#) sets out the billing and coding guidelines for professional medical services.

### Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- 16 – Claim/service lacks information which is needed for adjudication. Add'l info is supplied using remittance advice remarks codes whenever appropriate.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 950 – Please resubmit your bill with the report included for review.

### Issues

1. Is the insurance carrier's denial supported?

### Findings

1. The requestor is seeking reimbursement of Code 90837 for dates of service March 24, 2023, March 31, 2023 and April 7, 2023. The insurance carrier denied the disputed services for lack of information.

Review of the CPT Code 90837 description found – "Psychotherapy, 60 minutes with patient."

Review of the submitted "Visit Notes" found the following.

- Encounter date: March 24, 2023, Session Details: 01:00-01:053 (53 minutes)
- Encounter date: March 31, 2023, Session Details: 01:00-01:53 (53 minutes)
- Encounter date: April 07, 2023, Session Details: 01:05-02:00 (55 minutes)

DWC Rule 28 TAC §134.203(b)(1) states in pertinent parts, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply Medicare payment policies, including its coding; billing..."

Based on the above, the Division finds the insurance carrier's denial is supported as the submitted documentation does not support that a total of 60 minutes was spent with the patient on the disputed dates of service.

No payment is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requestor has not established that reimbursement is due.

**Order**

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to \$0.00 reimbursement for the disputed services.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

November 15, 2023  
Date

**Your Right to Appeal**

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at [www.tdi.texas.gov/forms/form20numeric.html](http://www.tdi.texas.gov/forms/form20numeric.html). DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).

The party seeking review of the MFDR decision must deliver a copy of the request to all other

parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in [28 TAC §141.1\(d\)](#).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).