**Texas Department of Insurance, Division of Workers' Compensation**
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

**Type of Requestor:** (x) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

| | |
|---|---|
| Requestor's Name and Address:<br>Texas Health<br>P.O. Box 600324<br>Dallas, TX 75360 | MDR Tracking No.: M4-05-6981-01<br>Claim No.:<br>Injured Employee's Name: |
| Respondent's Name and Address:<br>City of Dallas<br>C/o Harris & Harris<br>Rep Box #: 42 | Date of Injury:<br>Employer's Name: City of Dallas<br>Insurance Carrier's No.: 20041456 |

## PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Requestor's position summary states in part, "…TWCC fee guideline for CPT code 90801 is $193.40 per unit. As our bill and subsequent documentation show, we provided 5 units of CPT code 90801. The amount due is $967.00…"

Principle Documentation:

1. Position Summary
2. EOBs
3. CMS-1500
4. Clinical notes and Assessment

## PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Respondent's position summary states in part, "…The Respondent is reviewing the matters made the basis of this dispute in light of the information contained within the Requestor's medical dispute resolution filing. Should the Respondent's position in this matter change, it will notify both the Requestor and the Commission immediately…"

Principle Documentation:

1. Position Summary
2. EOB

## PART IV: SUMMARY OF DISPUTE AND FINDINGS

| Date(s) of Service | Denial Code | CPT Code(s) or Description | Part V Reference | Additional Amount Due (if any) |
|---|---|---|---|---|
| 09/10/04 | F | 90801 – Psychological Interview | 1 | $00.00 |
| TOTAL DUE | | | | $00.00 |

## PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

1. According to the 2002 Medical Fee Guideline and Medicare/AMA this code is no longer considered a timed code. The Respondent paid the Requestor $193.40 for the Psychological Interview, which according to the Medicare Fee Schedule and the added 125% is the correct reimbursement. Therefore, additional reimbursement is not recommended.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION**

28 Texas Administrative Code Sec.§ 413.011(a-d)
28 Texas Administrative Code Sec. §134.202

**PART VII: DIVISION DECISION AND ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the Division has determined that the requestor **is not** entitled to reimbursement.

**Decision by:**

| | Marguerite Foster | November 22, 2005 |
|---|---|---|
| Authorized Signature | Typed Name | Date of Order |

**PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW**

Appeals of medical dispute resolution decisions and orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005]. An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. The Division is not considered a party to the appeal.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**