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: Behavioral Healthcare Associates 1100 Bridgewood Drive, Suite 108 Fort Worth, Texas 76112	MDR Tracking No.: M4-05-3117-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: City of Fort Worth C/o Barron Risk Management Service, Inc. Rep Box # 03	Date of Injury: Employer's Name: City of Fort Worth Insurance Carrier's No.: WC0320012013

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

"…Carrier states the test is global to WH. We state it was assessment of patient for WH."

Principle Documentation:
1. Requestor's position summary
2. TWCC 60/Table of Disputed Services
3. CMS 1500
4. Explanation of Benefits

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

"…We've provided an eob showing that the claimant had work hardening on 12-23-03. we've also provided a copy of the CARF standards for the program, which clearly state that a health & behavioral assessment are integral to the work hardening i.e. comprehensive occupational rehabilitation programs. The CPT codes 97545-WH & 97546-WH include behavioral assessment and other mental health services which enhance the ability of the employee to deal with their injury & return to work."

Principle Documentation:
1. Respondent's position summary
2. TWCC 60/Table of Disputed Services
3. CMS 1500
4. Explanation of Benefits
5. Occupational Rehabilitation Program from 2002 Standards Manual

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)
12/23/03	G	96150	1	$68.60
TOTAL DUE				$68.80

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

Section 413.011(a-d) titled (Guidelines and Medical Policies), and Commission Rule 134.202 titled (Medical Fee Guideline) effective August 1, 2003, set out reimbursement guidelines.

1. Code 96150 for date of service 12/23/03 was denied as "G". Carrier reimbursed the Requestor $00.00. According to the CMS CCI edits, CPT code 96150 is not considered an integral part of CPT codes 97545-WH and 97546-WH, therefore, separate payment for the services billed are considered justifiable and unbundling is not an issue. Per Rule 134.202, reimbursement shall be according to Medicare plus 125%. Medicare pricing is $68.80 ($27.52 x 125% = $34.40 x 2 units = $68.80). Therefore, reimbursement in the amount of $68.80 is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.201
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** entitled to additional reimbursement in the amount of **$68.80**. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30-days of receipt of this Order.

Ordered by:

Authorized Signature	Typed Name	01/27/06 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.