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 4101 Greenbriar, Ste. 115 Houston, TX 77098	MDR Tracking No.: M4-05-4205-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Twin City Fire Insurance Co. C/o Hartford Financial Services Rep Box #: 27	Date of Injury: Employer's Name: Scott & White Memorial Hospital Insurance Carrier's No.: Twin City Fire Insurance Co.

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Requestor did not submit a position summary; however, the Requestor's rationale on the TWCC-60, Table of Disputed Services states, "Carrier did not pay per MAR. We do not have a contracted rate with the carrier. Carrier has incorrectly listed our facility as a participant in their network."

Principle Documentation:

1. TWCC-60/Table of Disputed Services
2. CMS-1500
3. EOBs

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Respondent did not reply to the Requestors' request for Medical Dispute Resolution.

Principle Documentation: 1. N/A

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)
02/10/04 and 02/24/04	C	96152 - Health and behavior intervention, each 15 minutes, face-to-face; individual	1	$23.12
TOTAL DUE				$23.12

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. CPT Code 96152 (4 units) for dates of service 02/10/04 and 02/24/04 denied as "C – Paid in accordance with Affordable PPO". The health care provider states in their rationale on the Table of Disputed Services that they do not have a contracted rate with the Insurance Carrier. The Insurance Carrier has not responded to the Request for Medical Dispute Resolution and has not submitted any pertinent information to support the healthcare provider has a contractual agreement. According to the Medicare Fee Schedule plus 125% this code is paid at $29.43 per unit; the healthcare provider billed 4 units for each date of service equaling a total of $117.72 for each date of service. The insurance carrier made payment of $105.96 for each date of service leaving a balance of $11.56 per date of service. Per Rule 134.202(b) reimbursement in the amount of $23.12 ($11.56 x 2) 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 $23.12.**

Ordered by:

Authorized Signature	Marguerite Foster Typed Name	January 27, 2006 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.