



MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) Health Care Provider () Injured Employee () Insurance Carrier	
Requestors Name and Address: Behavioral Healthcare Associates 4101 Greenbriar, Ste. 115 Houston, TX 77098	MDR Tracking No.: M4-05-4207-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name: Tokio Marine & Fire Insurance Co. Rep Box #: 47	Date of Injury:
	Employer's Name: Sanden International USA Inc.
	Insurance Carrier's No.: WC0000012224

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Position Summary states in part, "...Commission rules specifically state that a carrier is liable for all reasonable and necessary medical costs when preauthorization of any care if the services were approved prior to providing services..."

Principle Documentation:

1. Requestor's position statement
2. DWC-60 and Table of Disputed Services
3. CMS-1500's and EOB's

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Respondent did not submit a response to the initial 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	V	90806 – PsytX	1	\$124.80
TOTAL DUE				\$124.80

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

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

The disputed issue is non-payment of CPT Code 90806 for date of service 02/10/04 denied as "ZFK – The charge for this procedure exceeds the fee schedule or usual and customary allowance", "ZFL – This contracted provider has agreed to reduce this charge below fee Schedule or usual and customary charges for your business", and "V – Unnecessary treatment (w/o peer review) ."

1. The Requestor submitted a letter from First Health Network stating that the Requestor is no longer under a PPO contract. Per Rule 133.301(a) the Respondent shall not retrospective review services that have been preauthorized with authorization number WC00001224. Therefore, per Rule 134.202 reimbursement in the amount of \$124.80 is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §133.301(a)
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 \$124.80. The Division hereby **ORDERS** the Respondent 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:

Marguerite Foster

September 21, 2006

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.