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: Texas Health P.O. Box 600324 Dallas, TX 75360-0324	MDR Tracking No.: M4-05-4445-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Corpus Christi ISD C/o Harris & Harris Box 42	Date of Injury: Employer's Name: Corpus Christi ISD Insurance Carrier's No.: 0027958785

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Requestor's position summary states in part, "…[Injured Worker's] injury is compensable and the date of service in question should be paid due to the medical necessity established by the treating doctor of record…"

Principle Documentation:

1. Requestor's position summary
2. HCFA 1500's
3. EOB's

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Respondent did not submit a response to the Request for Medical Dispute Resolution.

Principle Documentation: 1. N/A

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
02/22/04	90801	1	$182.15
TOTAL DUE			$182.15

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, sets out reimbursement guidelines.

This dispute relates to procedure 90801(Psychiatric Diagnostic Interview) denied as "E – Entitlement to Benefits." On September 27, 2004 a Contested Case Hearing was held and adjudicated for the claimant; therefore, the disputed date of service is eligible for review by Medical Dispute Resolution.

1. CPT Code 90801 - Documentation submitted by the requestor indicates that services were rendered as billed. Reimbursement in the amount of $182.15 ($145.72 x 125%) is recommended.

Therefore it is the conclusion of the Medical Review Division that additional reimbursement in the amount of $182.15 is due the requestor.

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 entitled to additional reimbursement in the amount of **$182.15**. 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:

	Marguerite Foster	January 5, 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.