



## MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

### PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (x) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address: Texas Health P.O. Box 600324 Dallas, TX 75360	MDR Tracking No.: M4-05-4831-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Dallas ISD C/o Harris & Harris Rep Box #: 42	Date of Injury:
	Employer's Name: Dallas ISD
	Insurance Carrier's No.: 2004032788

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

The Requestor's position summary states in part, "... Texas Health conducted the initial diagnostic interview on 5/21/04. This interview does not require pre-authorization per TWCC Rule 134.600. This interview was necessary in order to determine what treatment path would be needed to best suit [injured workers'] condition. Subsequent services were pre-authorized explicitly using this evaluation. As previously stated, our facility treated the patient further compensable injury with services that were pre-authorized. The denial code R should not apply to this claim..."

Principle Documentation:

1. Requestor's position summary
2. TWCC-60/Table of Disputed Services
3. CMS-1500
4. EOBs

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

The Respondent did not submit a position summary; however, the Respondent's rationale for maintaining the reduction or denial located on the Table of Disputed Services states, "12/21/05 An add'l allowance of \$193.40 has been recommended as procedure provided is not a timed code."

Principle Documentation:

1. TWCC-60/Table of Disputed Services
2. Payment History for Injured Worker

### 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)
05/21/04	R1	CPT Code 90801 – Psych Dx Interview	1	\$00.00
<b>TOTAL DUE</b>				<b>\$00.00</b>

### 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 90801 for date of service 05/21/04 was denied as "R1 – Extent of Injury". A review of the DWC database reveals no current TWCC-21 was on file denying as "Extent of Injury". Review of the Respondents' response to the request for medical dispute resolution reveals the Carrier has made payment for the dispute date of service. On January 30, 2006 the adjuster was contacted and asked to submit a payment record for the disputed date of service. The adjuster submitted a payment history that shows this CPT code was reimbursed with check number 52141 dated 12/29/05 in the amount of \$193.40; therefore, the disputed date of service has been paid and reimbursement cannot be 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 not** entitled to reimbursement.

Decision by:

Marguerite Foster

February 3, 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.**