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	MDR Tracking No.: M4-05-4798-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: City of Dallas C/o Harris & Harris Rep Box #: 42	Date of Injury: Employer's Name: City of Dallas Insurance Carrier's No.: 20031811

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Requestor's position summary states in part, "…CPT Code 90901 has been paid at a rate far below usual and customary… CPt Code 90889 refers to the report charge…"

Principle Documentation:

1. Position Summary
2. EOBs
3. CMS-1500
4. Clinical notes

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Respondent's position summary states in part, "…Attached please find documents relevant to this dispute. Specifically you will find CMS-1500s and Explanation of Benefits/TWCC-62s from Fair Isaac, the utilization review company for Ward North America/City of Dallas, as well as payment information pertinent to this matter…"

Principle Documentation:

1. Position Summary
2. CMS-1500s
3. EOBs

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)
04/21/04, 04/27/04, 05/03/04, 05/10/04	S	90901 - Biofeedback	1	$00.00
04/21/04, 04/27/04, 05/03/04, 05/10/04	G	90889 – Report	2	$00.00
TOTAL DUE				$00.00

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

Section 413.011(a-d) titled (Guidelines and Medical Policies), and Commission Rule 134.201 titled Medical Fee Guideline for Medical Treatments and Services Provided Under the Texas Worker's Compensation Act) effective April 1, 1996, set out reimbursement guidelines.

1. The Respondent denied CPT Code 90901 using payment exception code "S – Upon final audit, additional benefit is recommended for billed service(s)." According to the 2002 Medical Fee Guideline and Medicare/AMA this code is no

longer considered a timed code. The Respondent paid the Requestor $53.06 for each date of service, which according to the Medicare Fee Schedule and the added 125% is the correct reimbursement. Therefore, additional reimbursement is not recommended.

2. The Respondent denied CPT Code 908890 using payment exception code "G90 – G - Unbundling." According to the AMA CPT codebook, 2004 edition, the report is included in the primary procedure code billed. Therefore, per §134.202(b) and (c) reimbursement is not recommended.

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 not** entitled to reimbursement.

Decision by:

	Marguerite Foster	November 22, 2005
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.