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, Suite 115 Houston, Texas 77098	MDR Tracking No.: M4-05-6439-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Zurich American Insurance Company C/o Falhive Ogden & Latson Rep Box # 19	Date of Injury: Employer's Name: Sanmina SCI Corp. Insurance Carrier's No.: 001671007836WC01

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

"Carriers rationale is invalid. Our provider is not required to be on the ADL list as we are a psychological facility. The patient was referred by the treating doctor who is on the approved doctors list."

Principle Documentation:
1. Requestor's position summary
2. TWCC 60/Table of Disputed Services
3. CMS 1500
4. Explanation of Benefits
5. Report dated 07/27/04

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

"…Fee Guideline MAR Reduction.".

Principle Documentation:
1. Requestor's position summary
2. TWCC 60/Table of Disputed Services

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)
07/27/04	F, K	90882 (Environmental Intervention for Medical management)	1	$40.00
TOTAL DUE				$40.00

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

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

1. Code 90882 for date of service 07/27/04 was denied as "F—Fee Guideline MAR Reduction" and "K—Not Appropriate Health Care Provider". Per Rule 180.22(c)(1), the treating doctor may approve all health care provided to the injured worker including referrals. Rule134.202(c)(6) states, "for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assigned a relative value, which may be based on nationally recognized published relative studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments." Carrier failed to assign a relative value and reimburse the Requestor $00.00. Requestor billed the Respondent $40.00 for CPT code 90882. Therefore, reimbursement in the amount of $40.00 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
28 Texas Administrative Code Sec. §134.202(c)(6)

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 reimbursement in the amount of **$40.00**. 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:

Authorized Signature	Typed Name	02/08/06 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.