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, Ste. 115 Houston, TX 77098	MDR Tracking No.: M4-05-6463-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Albertsons, Inc. C/o Flahive, Ogden & Latson Rep Box #: 19	Date of Injury: Employer's Name: Albertsons, Inc. Insurance Carrier's No.: YGU00663

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Requestor's position summary states in part, "…The carrier reimbursed below the fee guidelines. The carrier has denied reimbursement for DOS: 7/15/04 which includes procedure 90825 (review of records). The carrier's rationale for denial is 'invalid/not covered code.' We disagree with the carrier's rationale as the carrier must review the procedure in question and give a reasonable reimbursement amount for the services in question. The carrier must assign a reimbursement amount…"

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's position summary states in part, "…A provider must make a timely and valid request for reconsideration before requesting medical dispute resolution. 28 TAC 133.304(m). The request for reconsideration must include three items: (1) a copy of the original bill, with the identical codes and charges as the original bill, and clearly marked with the statement: 'REQUEST FOR RECONSIDERATION'; (2) a copy of the carrier's original explanation of benefits; and (3) a claim-specific substantive explanation of the provider's position. 28 TAC 133.304(k). The claim-specific substantive explanation must be more than a mere generic statement such as 'insurance carrier improperly reduced the bill.' 28 TAC 133.304(k)(3). In the immediate case the provider has failed to submit any claim-specific substantive explanation with its request for reconsideration. All that was submitted was the original bill stamped 'REQUEST FOR RECONSIDERATION' and the EOB. Accordingly, the request was not complete and fails to satisfy the prerequisite for medical dispute resolution. This matter is not ripe for review and should be dismissed pursuant to 28 TAC 133.307(m)(3). Carrier asserts that it reimbursed Provider according to the Texas Labor Code, Texas Administrative Code, and Medical Fee Guidelines. In addition, CPT Code 90825 is not recognized by Medicare as a valid code, and therefore, no reimbursement is due for this service…"

Principle Documentation:

1. Respondent' 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)
04/22/04, 06/01/04, 06/15/04	F, G, S	96100 – Psychological Testing 90806 – Psychotherapy 96152 – Health and behavior intervention	1	$6.39
07/15/04	No EOB	90825 – Review of Records 96150 - Health and behavior assessment	2	$00.00
TOTAL DUE				$6.39

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 96100 for date of service 04/22/04. The carrier made an initial payment in the amount of $282.72 and used payment exception code "F"; upon reconsideration the carrier used payment exception code "O". Per Rule 134.202(b) additional reimbursement in the amount of $6.33 ($77.08 x 125% = $96.35x 3 units = $289.05 – $282.72, carrier payment) is recommended.

CPT Code 90801 for dates of service 06/01/04, 06/15/04, and 06/22/04. The carrier made an initial payment in the amount of $119.81 for each date of service and used payment exception code "F", upon reconsideration the carrier used payment exception code "O". The CMS-1500 submitted for review lists the place of service (Item 24B on the CMS-1500) as "62" which is used for facility reimbursement; therefore, per Rule 134.202(b) additional reimbursement in the amount of $0.06 ($95.86 x 125% = $119.83 x 3 = $359.49 - $359.43, carrier payment for dates of service listed) is recommended.

2. CPT Code 90825 for date of service 07/15/04. The Carrier's audit company, Concertra Integrated Services, Inc., did not respond to the initial billing with a standard EOB but per Rule 133.300(d) replied to the Requestor with a letter, dated 08/25/04, which states in part, "In order for us to complete processing of the referenced bill, please provide the information indicated below. Submit the correct procedure code. The following is invalid: 90825…" According to the Center for Medicare Services this code was deleted in 1998 and therefore invalid for this date of service. Also, the Requestor's request for reconsideration was not submitted in a timely manner. The request for reconsideration was made on 04/07/05; according to Rule 133.304(m) the Requestor filed for medical dispute resolution on 04/15/05 and therefore did not allow ample time for the Carrier to respond to the reconsideration. Per Rule 133.304(m) and 134.202(b) reimbursement is not recommended.

CPT Code 96150 for date of service 07/15/04. The Carrier's audit company, as listed above, did not review this CPT Code. Per Rule 133.1(3)(C) the Requestor must include correct billing codes according to Rule 133.202(b). Per Rule 133.300(d) the Carrier's audit company submitted a letter requesting the Requestor to submit the correct procedure code. The Requestor did not make a correction to the bill and the request for reconsideration was made on 04/07/05; according to Rule 133.304(m) the Requestor filed for medical dispute resolution on 04/15/05 and therefore did not allow ample time for the Carrier to respond. Per Rule 133.304(m) 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. §134.201
28 Texas Administrative Code Sec. §134.202
28 Texas Administrative Code Sec. §134.304

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 $6.39.**

Ordered by:

	Marguerite Foster	March 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.