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.: M4-05-8206-01 Claim No.: Injured Employee's Name:
Respondent's Name: American Home Assurance Rep Box #: 19	Date of Injury: Employer's Name: Adminstaff Inc. Insurance Carrier's No.: YBUC 74975

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Position Summary states in part, "…Carrier reduced reimbursement for Procedure 90801. The rationale used was "fee guideline reduction." We disagree with the carrier's rationale as the guideline was not met. Carrier denied reimbursement for Procedure 96152. The rationale used was "not treating doctor". We disagree with the carrier's rationale as the patient was referred to us by the treating physician for evaluation and treatment. All treatment was prescribed and reviewed by the treating doctor…"

Principle Documentation:

1. DWC-60/Table of Disputed Services/Position Summary
2. CMS-1500's
3. EOB's
4. Pertinent Medical Records
5. Preauthorization approval

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Respondent did not submit a position summary; however, the Respondent's rationale, listed on the Table of Disputed Services, states, "pd per fee. Denied for authorization."

Principle Documentation: 1. DWC-60 response

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)
05/13/04	No Denial Code	90801	1	$00.19
07/02/04, 07/16/04, 07/28/04	A, L	96152 x 4 units x 3 dates of service	2	$372.84
TOTAL DUE				$373.03

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

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

1. CPT Code 90801 for date of service 05/13/04: The EOB submitted by the Requestor contained no denial codes for this particular CPT Code. The Requestor billed $210.00 and the Respondent paid $181.78. Per the 2002 Medical Fee Guideline, Rule 134.202(b) the maximum allowable reimbursement for this code is $181.97 for facility fees for place of service "62" located in box 24B of the CMS-1500; therefore, additional reimbursement in the amount of $.19 is recommended.

2. CPT Code 96152 for dates of service 07/02/04, 07/16/04 and 07/28/04: The Respondent denied CPT Code 96152 for "A – Preauthorization Not Obtained" and "L – Not Treating Doctor." Per Rule 134.600 the Requestor submitted a copy of the preauthorization approval for the disputed dates of service. Per Rule 180.22(e) the Requestor submitted medical records to support the treating doctor referred the injured worker for evaluation and treatment; therefore, reimbursement in the amount of $372.84 is recommended.

Total reimbursement amount due to the Requestor is $373.03.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 413.011(a-d)
28 Texas Administrative Code Sec. §134.1
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 $373.03. The Division hereby **ORDERS** the Respondent 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	August 29, 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.