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.: M4-05-8342-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Bankers Standard Insurance Company C/o Ace USA/ESIS Rep Box # 15	Date of Injury: Employer's Name: HMS Host Corp. Insurance Carrier's No.: 000566002886WC01

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

"…Carrier did not reimburse according to Fee Guidelines, only reimbursed for 1 unit. We charged 4 units. NO a duplicate bill."

Principle Documentation:
1. Requestor's position summary
2. TWCC 60/Table of Disputed Services
3. CMS 1500
4. Explanation of Benefits
5. Report dated 05/27/04

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Respondent did not submit a response to this request for dispute resolution.

Principle Documentation:
1. N/A

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)
05/27/04	F	96152 x 4 units (Intervene Health/Behave, Individual)	1	$90.54
TOTAL DUE				$90.54

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 96150 x 4 units for date of service 05/27/04 was denied as "F". Carrier reimbursed the Requestor $30.18. Per Rule 134.202, reimbursement shall be according to Medicare plus 125%. Medicare pricing is $124.44 ($24.89 x 125% = $31.11 x 4 units = $124.11). Per the Requestors Table of Disputed Services, the amount in dispute is $90.54. Therefore, reimbursement in the amount of $90.54 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

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 **$90.54**. 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:

		02/08/06
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.