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 77096	MDR Tracking No.: M4-05-9349-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Texas Mutual Insurance Co. Rep Box #: 54	Date of Injury: Employer's Name: REM Torque Test, Inc. Insurance Carrier's No.: 99A0000265702

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Requestor's position summary states in part, "…The carrier has denied procedure 90889 and 96151. The rationale used by the carrier is 'Fee Guideline reduction.' We disagree with the carrier's rationale as the carrier paid below the established MAR for the services in question. Carrier has denied reimbursement for procedure 96152 using rationale 'no preauthorization obtained.' We disagree as preauthorization was obtained (#EPG021316P)…"

Principle Documentation:

1. Requestor's position summary
2. CMS-1500
3. EOBs

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Respondent's position summary states in part, "…Regarding code 90889 for this date of service, it is this carrier's position that based on the bundled status assigned to this code, no reimbursement is due… Medicare does not reimburse code 90889, as it is a bundled code… Upon review, this carrier will reimburse the requester for codes 96151 and 96152. Reimbursement will follow under separate cover. Reimbursement was made on 06/28/05 I the amount of $192.38 plus $9.70 interest with check number 09654583…"

Principle Documentation:

1. Respondent's position summary
2. 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)
06/10/04	F, 891	90889 – Report Preparation	1	$00.00
06/10/04	891	96151-59 – Health Reassessment	2	$00.00
06/10/04	930	96152 – Health Intervention	3	$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 134.202 titled Medical Fee Guideline effective August 1, 2003, set out reimbursement guidelines.

1. CPT Code 90889 for date of service 06/10/04 denied as "F, 891 – The Insurance Company is reducing or denying payment after reconsideration ." In the Carrier's response they indicate that this code is a bundled code. According to CMS CCI edits this CPT Code is considered a bundled code and not separately reimbursable. Per Rule 134.202(b) reimbursement is not recommended.

2. CPT Code 96151-59 for date of service 06/10/04. The Carrier has reviewed this procedure and determined that payment is being allowed based upon a dispute. Per Rule 134.202(b) the Carrier has issued the correct payment in the amount of $130.16 plus interest with check number 09654583. Therefore, no additional reimbursement is recommended.

3. CPT Code 96152-59 for date of service 06/10/04. The Carrier has reviewed this procedure and determined that payment is being allowed based upon a dispute. Per Rule 134.202(b) the Carrier has issued the correct payment in the amount of $62.22 plus interest with check number 09654583. Therefore, no additional reimbursement 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 not** entitled to additional reimbursement.

Decision by:

	Marguerite Foster	January 27, 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.