Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Buena Vista Workskills 5445 La Sierra Dr. #204 Dallas, Texas 75231	MFDR Tracking #: M4-05-A281-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: COMMERCE & INDUSTRY INSURANCE BOX 19	Date of Injury: Employer Name: SHELTER CORP Insurance Carrier #: 077094641

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "It is our position that AIG has established an unfair and unreasonable time frame in paying for the services that were authorized and rendered to the injured worker. Your help in resolving this case is appreciated."

Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)
3. EOB(s)

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "The carrier asserts that it has paid according to applicable fee guidelines…Further, the carrier challenges whether the charges are consistent with applicable fee guidelines. All reductions of the disputed charges were made appropriately."

Principle Documentation:

1. Response to DWC 60
2. EOB(s)

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
8-9-04	U301	90806	1, 2	$118.00
Total Due:				$118.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

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

The Requestor sent a revised Table of Disputed Services on 1-22-07. This Table will be used for this review.

1. These services were denied by the Respondent with reason code "U301-This item was previously submitted and reviewed with notification of decision issued to payor/provider (duplicate invoice). The disputed service was a duplicate bill submitted for reconsideration of payment.

2. Per review of Box 32 on CMS-1500, zip code is located in Bexar County.

3. Per Rule 134.600 (h) the Requestor provided a copy of a preauthorization letter dated 6-8-04 (#015943401) for 6 visits of Individual Psychotherapy. Reimbursement per Rule 134.202(c)(1) is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.1, §134.202, §134.600

PART VII: DIVISION DECISION AND/OR 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. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $118.00 plus accrued interest, due within 30 days of receipt of this Order.

ORDER:

7-9-07

Authorized Signature	Medical Fee Dispute Resolution Officer	Date

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.