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-A353-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: TPCIGA for United Pacific Insruance Rep Box #: 50	Date of Injury: Employer's Name: Trinity Industries, Inc. Insurance Carrier's No.: TRIN000313

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Requestor's position summary states in part, "…The carrier reduced reimbursement for procedure 96150. The rationale used by the carrier was 'fee guideline MAR reduction.' We disagree with the carrier's rationale as the carrier did not reimburse the correct number of units billed…"

Principle Documentation:

1. TWCC-60
2. Requestor's position statement
3. EOB
4. CMS-1500
5. Clinical Notes

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Respondent did not submit a response to the Request for Medical 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)
07/16/04	F	96150 - Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment	1	$41.69
TOTAL DUE				$41.69

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 96150 (4 units) for date of service 07/16/04 denied as "F – Fee Guideline MAR reduction". According to the CMS CPT descriptor this code is considered a health and behavior assessment, each 15 minutes face-to-face with the patient; initial assessment. Per §134.202(b) additional reimbursement in the amount of $41.69 ($26.37 x 125% = $32.96 x 4 = $131.84 - $90.15, Carrier payment) 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 $41.69.**

Ordered 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.