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: Steven S. Callahan, PH.D & Associates 4101 Greenbriar, Suite 115 Houston, TX 77098	MDR Tracking No.: M4-05-B102-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: University Of Texas System Rep Box # 46	Date of Injury: Employer's Name: University Of Texas System Insurance Carrier's No.: 04B0336

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor states the carrier is required to abide by the established fee guideline rules.

Principle Documentation:

1. Requestor's position statement
2. TWCC-60
3. EOB's
4. HCFA's

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent stated they miscalculated the MAR for CPT 90801 and will issue payment an d CPT code is not separately payable.

Principle Documentation: 1. TWCC-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)
08/09/04	F	90801	1	$00.00
08/09/04	G	90889	2	$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 90801 for date of service 08/09/04 denied with "F", The insurance carrier made a payment of $181.77 for this date of service. The requestor believes that the respondent did not pay according to the Medical fee Guideline and a balance of $10.82 is due the requestor. According to Rule 134.202(b) for coding, report and reimbursement system participants shall apply the Medicare program reimbursement methodologies. The submitted CMS-1500 for date of service 08/09/04 list the place of service as "62", the definition of "62" is a Comprehensive Outpatient Rehabilitation facility. Under Medicare reimbursement facility fees are paid at a lower rate than non-facility fees. The facility rate for the disputed procedure is $145.42 x 125% = $181.78. Therefore, per the 2002 Medical fee Guideline, the respondent has reimbursed the requestor accordingly and additional reimbursement is not recommended.
2. CPT Code 90889 for date of service 08/09/04 denied with "G", Per Rule 134.202(b) and CMS this code is considered by Medicare to be a bundled code and not eligible for reimbursement.

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**.**

Ordered by:

		02/24/06
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.