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:	MDR Tracking No.: M4-05-B177-01
Active Behavioral Health 2500 West Freeway # 200 Fort Worth, Texas 76102	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
Sierra Insurance Company of Texas Box 17	Employer's Name:
	Insurance Carrier's No.: 423200013100

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: DWC-60, CMS 1500s, medical documentation, copy of preauthorization, explanation of benefits
POSITION SUMMARY: From table of disputed services "Preauthorized"

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60 and explanations of benefits, copy of required medical examination report
POSITION SUMMARY: "The TWCC-60 from the Requestor, Active Behavioral Health, lists the dispute as one of a fee dispute. However, as the some of treatments provided by the Requestor have been denied pursuant to a peer review, this is a retrospective medical necessity dispute and should be re-docketed to reflect that dispute. This case should be appointed to an IRO for determination."

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
01-21-05, 01-28-05, 03-04-05 and 03-23-05	90806	(1)	$0.00
03-30-05 and 04-13-05	90806	(2)	$249.60
03-02-05	99361	(3)	$53.00

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

(1) Services were preauthorized. Carrier has indicated payment was made. The Requestor was contacted on 11-16-05 and payment was confirmed to have been made by the carrier. Services are no longer in dispute.

(2) Services were denied for unnecessary medical treatment based on peer review/Adjustment due to State Fee Schedule with denial codes W9MA. The services were preauthorized. Per Rule 134.600(b)(1)(B) reimbursement is recommended in the amount of **$249.60 ($124.80 billed X 2 DOS).**

(3) Service was denied for unnecessary medical treatment based on peer review/Adjustment due to State Fee Schedule with denial codes W9MA. Code 99361 is governed by the 2002 Medical Fee Guideline. "Telephonic case management is not eligible for a medical necessity determination if the service meets the conditions/criteria set forth by Rule 134.202 and therefore will be processed according to the Medical Fee Guideline". The Requestor submitted documentation for review that supports the service billed. Reimbursement is recommended in the amount of **$53.00.**

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 134.202, 134.600(b)(1)(B)

PART VII: DIVISION DECISION

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 $302.60.

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.

Findings and Decision by:

Authorized Signature		Date of Order
		11-17-05

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.