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: Active Behavioral Health 2500 West Freeway # 200 Fort Worth, TX 76106	MDR Tracking No.: M4-07-0517-01 Claim No.: Injured Employee's Name:
Respondent's Name: Fidelity & Guarantee Insurance Rep Box # 19	Date of Injury: Employer's Name: Clayton Homes Inc. Insurance Carrier's No.: 9000582029

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary states in part, "…All psychotherapy and individual sessions were preauthorized. This claim is compensable beyond any doubts…"

Principle Documentation: 1. DWC 60 package
2. CMS 1500's
3. EOBs

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent did not submit a response.

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)
11/18/05	147,W1	90806-Psychotherapy	1	$123.29
12/02/05	W1,663	90806-Psychotherapy	2	$123.29
TOTAL DUE				$246.58

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

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

1. CPT Code 90806 for date of service 11/18/05 denied with "147-Workers Compensation State Fee Schedule adjustment", "W1-Workers Compensation State Fee Schedule Adjustment". Per Rule 134.202 (c) (1) reimbursement in the amount of $123.29 is recommended.

2. CPT Code 90806 for date of service 12/02/05 denied with "W1-Workers Compensation State Fee Schedule adjustment", "663-Reimbursement has been calculated according to the state fee schedule guidelines". Per Rule 134.202(c) (1) reimbursement in the amount of $123.29 is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code Sec. 413.011(a-d)
28 Texas Administrative Code Sec. §134.1
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 **$246.58**. 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.

Ordered by:

		12/08/2006
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.