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 75102	MDR Tracking No.: M4-07-0640-01 Claim No.: Injured Employee's Name:
Respondent's Name: Texas Construction Trust Rep. Box # 42	Date of Injury: Employer's Name: Brazos Masonry Inc. Insurance Carrier's No.: 485452

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary as listed on the Table of Disputed Services: "4-7-06, CPT code 90885, No EOB Provided; 5-25-06 thru 6-8-06 – Preauthorized."

Principle Documentation: 1. DWC 60 package
2. CMS 1500's
3. Preauthorization Report
4. Medical Reports

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary states in part, "Carrier has elected to pay the services in dispute. Enclosed please find the EOBs and proof of payment."

Principle Documentation: 1. Response to DWC 60
2. Explanation of Benefits, (EOBs)

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)
4-7-06	No EOB	90885	1-9	$00.00
5-25-06 5-26-06 5-30-06 6-6-06	No EOB	97799-CP (7 hours x 4 dates = 28 hours)	1-8, 10	$2800.00
5-31-06 6-1-06 6-2-06 6-5-06 6-7-06 6-8-06	No EOB	97799-CP (8 hours x 6 dates = 48 hours)	1-8, 10	$4800.00
TOTAL DUE				$7,600.00

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. This dispute relates to procedures/services that were billed under CPT codes 90885 and 97799-CP that were denied reimbursement by the insurance carrier.

2. On 1-29-07, the Division contacted the Respondent's representative, Christina, and requested copies of EOBs for the disputed services. To date, the EOBs for the disputed services have not been submitted to the Division.

3. The Respondent submitted copies of EOBs in their response to the dispute that showed payment for services that are not listed on the DWC-60.

4. On February 12, 2007, the Division contacted the Requestor and verified that the listed services have not been paid and remains in dispute.

5. The Respondent did not comply with Rule 133.307(e)(3) by submitting the missing EOBs for the disputed services. Since the insurance carrier did not raise the issue in their response that they had not had the opportunity to audit these bills and did not submit copies of the EOBs, the Medical Dispute Resolution Division will review these services per *Medical Fee Guideline (MFG).*

6. Per Rule 133.307(d), the request for medical dispute resolution was received in the Division on 9-28-06.

7. Based on Division Rule 133.307(d)(1-2), the only dates of service eligible for review are those commencing on 4-7-06 and extending through 6-8-06.

8. On May 8, 2006 the Respondent gave preauthorization approval for 10 CPMP sessions; therefore, preauthorization is not an issue in dispute.

9. Per Rule 134.202, CPT code 90885 is a bundled code; therefore, reimbursement is not recommended.

10. Per Rule 134.202(e)(5)(A)(ii) reimbursement for non-CARF accredited programs is 80% of the MAR. Rule 134.202(e)(5)(E) states that reimbursement for Chronic Pain Management/Interdisciplinary Pain Rehabilitation Program is $125.00/hr. for CARF accredited program; therefore, a non-CARF accredited programs' MAR is $100.00/hr. The Requestor billed for a total of 76 hours X $100.00 = $7,600.00.

Therefore it is the conclusion of the Medical Dispute Resolution that additional reimbursement in the amount of $7,600.00 is due the Requestor.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 413.011(a-d)
28 Texas Administrative Code Sec. §134.1
28 Texas Administrative Code Sec. §134.202
28 Texas Administrative Code Sec. §133.307

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 **$7,600.00.** 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:

	Elizabeth Pickle, RHIA	March 5, 2007
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.