Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Active Behavioral Health 2420 E. Randol mill road Arlington, Texas 76011-6335	MFDR Tracking #: M4-07-2020-01
	DWC Claim #:
	Injured Employee:
Respondent Name: American Home Assurance Co.	Date of Injury:
Box #: 19	Employer Name: Jerusalem Corporation
	Insurance Carrier #: 7092288360000

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "Provider sent a request for reconsideration on October 25, 2006. Proof that carrier received request is also included. Carrier chose not to respond within 28 day time frame rule…All Fee guidelines have been followed."

Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)
3. EOB(s)
4. Copy of preauthorizations

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "The agreement provides that the accepted compensable injury is bilateral inguinal hernia. The agreement does not provide that Carrier has accepted any diagnosis related to depression, anxiety, or any other psychological condition as a direct and natural result of the work-related injury. Therefore, Provider is treating a non-compensable condition."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Review of the box 32 on CMS-1500, revealed zip code 76011 is located in Tarrant county.

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
05-19-06	W12	90801 (1 session-not timed code)	1 - 3	$190.38
07-06-06, 07-11-06, 07-18-06, 07-25-06, 08-04-06, 08-10-06	50	90901 (1 session @ $ 50.88 x 6 DOS- not timed code)	3 - 5	$305.28
07-07-06 & 07-10-06	50	90806 (1 unit @ $122.91 x 2 DOS)	3 - 5	$245.82
08-29-06	50	90901	4 & 6	$00.00
09-14-06	NO EOB	96151	6 & 7	$00.00
Total Due:				$741.48

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

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

1. This service was denied by the Respondent with reason code “W12” (Workers’ compensation claim adjudicated as non-compensable. Carrier not liable for claim or service/treatment).

2. On 05-30-06 the parties agreed through a Benefit Dispute Agreement that the claimant did sustain a compensable injury on 10-17-05 in the form of a bilateral inguinal hernia. The Requestor billed with diagnosis 550.92 (bilateral inguinal hernia); therefore the compensable injury was treated.

3. Reimbursement is recommended per Rule 134.202(c)(1) in the following amounts: CPT code 90801 $190.38 (1 session @ $190.38 –not a timed code), CPT code 90901 $305.28 (1 session @ $50.88 x 6 DOS - not a timed code) and CPT code 90806 $245.82 (1 unit @ $122.91 x 2 DOS).

4. These services were denied by the Respondent with reason code “50” (These are non-covered services because this is not deemed a ‘medical necessity’ by the payer).

5. The Requestor obtained preauthorization (certification number 030177101) for biofeedback 6 sessions with a start date of 07-05-06 and an expiration date of 11-11-06. A preauthorization (certification number 029599401) for individual psychotherapy 3 sessions (once a week for 3 weeks) with a start date of 06-22-06 and an expiration date of 09-20-06 was also obtained prior to the Requestor rendering the services. The Respondent is in violation of Rule 134.600 (c)(1)(B) which states in part “The carrier is liable for all reasonable and necessary medical costs relating to the health care: preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care”.

6. Per Rule 134.600 preauthorization was required, but not obtained by the Requestor; therefore, no reimbursement is recommended.

7. Neither party submitted a copy of an EOB. Per Rule 133.307(e)(2)(B) the Requestor submitted proof of the Respondent’s receipt of the Requestor’s request for an EOB.

A Legal and Compliance referral is made due to the Respondent being in violation of Rule 134.600.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.1, §134.202, §134.600 and §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 reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $741.48 plus accrued interest, due within 30 days of receipt of this Order.

ORDER:

Authorized Signature	Medical Fee Dispute Resolution Officer	Date
		05-25-07

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.