Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
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: Allied Behavior Healthcare P.O. Box 257 Ferris, Texas 75125	MFDR Tracking #: M4-07-2363-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: Zurich American Insurance Company c/o Flahive, Ogden & Latson Box #19	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary states in part "…We received preauthorization for this treatment…"

Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)
3. EOB(s)
4. Preauthorization letter

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary states in part "…the EOB's indicate that the treatment underlying the charges in dispute were for body parts and/or conditions not related to the compensable injury…any request for resolution of a fee dispute and any request for an IRO must be held in abeyance until such liability disputes have been resolved by a final decision of the TWCC…"

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
6/16/06	W2,268,277	90801	1-3	$175.00
6/16/06	W2,268,277	96118	1-3	$900.00
Total Due:				$1,075.00

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, set out the reimbursement guidelines.

Per Box 32 of the CMS-1500 services were performed in Dallas County zip code 75225.

1. These services were denied by the Respondent with reason code "W2,268-Entitlement (non-compensable)" Upon request for reconsideration services were denied with reason code "277-These services/charges have been previously reviewed and allowance recommended on another analysis. Returned as a duplicate bill."

- Reimbursement for services was denied pending resolution of a dispute pertaining to liability for the claim. Per Contested Case Decision and Order, the claimant sustained a compensable injury on ___. The carrier has been ordered to pay benefits in accordance with this decision. Per teleconference with the Requestor on 06/13/07 the disputed services have not been paid. This order was signed June 27, 2006 and has become final. Reimbursement is recommended

A referral to Legal and Compliance has been made.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

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

PART VII: DIVISION 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 $1,075.00 plus accrued interest, due within 30 days of receipt of this Order.

ORDER :

		6/26/07
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

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.