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: North Texas Pain Recovery Center 6702 W. Poly Webb Road Arlington, TX 76016	MFDR Tracking #: M4-07-2541-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: 19 AMERICAN ZURICH INSURANCE CO.	Date of Injury: Employer Name: LEAR CORP Insurance Carrier #: YLLC18702

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "Since our charges for CPT code 96150 does not include reimbursement for reviewing the patient's medical records, we bill for this time with code 90885."

Principle Documentation:

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

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: The Respondent did not submit a response to the DWC-60.

Principle Documentation: None

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
05/31/06	62, W1	90885 (Status B Code)	1, 2	$00.00
05/31/06	W1, 97	96150 ($32.63 (MAR) x 16 units)	1, 3, 4	$522.08
	Total Due:			$522.08

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.

1. These above services were denied by the Respondent with reason code "62 – Payment denied/reduced for absence of or exceeded pre-certification/authorization. Preauthorization required but not requested" "w1 – Payment denied/reduced for absence of or exceeded pre-certification/authorization. Preauthorization required but not requested" and "97- Pymt is incl in the allow for another srvc. The srvcs listed under this procedure code are included in a more comprehensive code which accurately describes the entire procedure(s) performed."

2. Per Rule 134.202 (b) this code (90885) is a "Status B" code and separate reimbursement is not allowed, therefore, no reimbursement is recommended.

3. CPT code 96150 does not require preauthorization per rule 134.600. Reimbursement is recommended per Rule 134.202 (c) (1) in the amount of **$522.08.**

4. Per review of Box 32 on CMS-1500, zip code 76016 is located in Tarrant County.

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 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 $522.08 plus accrued interest, due within 30 days of receipt of this Order.

ORDER:

		07/06/07
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.