



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: Denise Turboff, L.P.C. 6660 Airline Dr. Houston, TX 77076	MDR Tracking No.: M4-07-3161-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name: Indemnity Insurance Company of NA Box 15	Date of Injury:
	Employer's Name: Yum Brands Inc
	Insurance Carrier's No.: 012006037270WC01

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Requestor did not submit a position summary.
 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 to DWC-60.

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)
6/20/06	18	90801	1, 2	\$194.65
TOTAL DUE				\$194.65

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 procedure 90801 (Psychiatric diagnostic interview examination), denied "18 – Duplicate claim/service."
2. The Respondent did not respond to the Division with documentation to support their denial "18-Duplicate claim/service." Therefore, per Rule 134.202(c)(1), reimbursement in the amount of \$194.65 (\$155.72 x 125%) is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 413.011(a-d)
28 Texas Administrative Code Sec. §133.307 (effective 12/31/06)
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 **\$194.65**. 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:

4/2/07

Authorized Signature

Medical Fee Dispute Resolution Officer

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.