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: BEHAVIORAL HEALTHCARE ASSOC. 2450 FONDREN RD STE 312 HOUSTON TX 77063-2323	MFDR Tracking #: M4-07-3429-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: ZURICH AMERICAN INSURANCE CO BOX 19	Date of Injury: Employer Name: ULTIMATE STAFFING SERVICES Insurance Carrier #: RTH0000190

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "All units have not been paid according to the services provided shown on the documentation…This date remains the only date not paid in full…This is a easy claim to resolve and should be done so [sic]in a timely manner, not one year later, through MDR."

Principle Documentation:

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

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "The carrier submits that all fee reductions were made in accordance with the applicable fee guidelines. The carrier further questions whether the charges for the service made the basis of this dispute are consistent with the applicable fee guidelines."

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
3-14-06	397	97799-CP ($100.00 x 3 units)	1, 2, 3	$300.00
Total Due:				$300.00

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, sets out the reimbursement guidelines.

1. These services were denied by the Respondent with reason code "397-Allowance is based on utilization review pre-authorization."

2. These services were preauthorized in a letter from Fair Isaac with Review # 199204 for 15 visits of a multidisciplinary pain program with a begin date of 2-13-06 and an end date of 3-17-06.

3. Per 134.202(e)(5)(E) the Chronic Pain Management Program shall be $100.00 per hour for a non-CARF accredited program. The Requestor provided 8 hours of this service. Recommend additional reimbursement of $300.00 as the Respondent has previously reimbursed $500.00 for five hours.

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

PART VII: DIVISION DECISION AND/OR 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. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $300.00 plus accrued interest, due within 30 days of receipt of this Order.

ORDER :

Authorized Signature	Donna D. Auby Medical Fee Dispute Resolution Officer	5-16-07 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.