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 Name and Address: North Texas Pain Recovery Center 6702 W. Poly Webb Rd Arlington, TX 76016	MFDR Tracking #: M4-07-3954-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: Twin City Fire Insurance Co Rep. Box # 27	Date of Injury:
	Employer Name: English Color & Supply Inc
	Insurance Carrier #: YMJC40499

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "…A provider can bill up to 16 units for this procedure…"

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: No response from Respondent

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and/or Description	Part V Reference	Amount Due
9/18/06	97	96150 ($26.10 x 125% x 16 units)	1-2	$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, sets out the reimbursement guidelines.

1. This dispute relates to procedure 96150 (Health & behavioral assessment) and Respondent's denial of payment based upon, initial denial-"97 – Included in the allowance for another service/procedure." Reconsideration denial was the same.

2. Per Rule 134.202(b), "CPT code 96150 is not included in the allowance for another service/procedure billed on the same date of service; therefore, payment of $522.08 is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

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

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 reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $32.63 plus accrued interest, due within 30 days of receipt of this Order.

Decision and Order:

	Scott Hansen	5/18/07
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.