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: Denise Turboff, L.P.C 6660 Airline Drive Houston, Texas 77037	MFDR Tracking #: M4-07-4086-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: Amerisure Insurance Co. c/o Burns Anderson Jury & Brenner Box #47	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary states in part: "Your facility has denied this claim based on an extent issue. The adjustor has filed a TWCC-21 based on a depression diagnosis. Our facility is using the diagnosis codes 724.4-lumbar Radiculitis and 553.1-Umbilical Hernia. Therefore, this service should NOT be denied based on an extent issue because we are NOT using a depression diagnosis."

Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)
3. EOB(s)
4. RFR & signed USPS certified green card

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary states in part: "…Currently, it is our position to stand firm on our prior decision. Attached you will find a copy of the PLN 11 that has been filed with the DWC supporting our position. In response to the requestor's statement that Amerisure did not respond to the request for reconsideration, it is our position we did not receive the RFR."

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
06/21/06	W12	90801	1	$194.65
Total Due:				$194.65

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 Harris County zip code 77076.

These services were denied by the Respondent with reason code "W12-Extent of injury. Not finally adjudicated. PLN 11 DENIAL PER ADJUSTER".

The Requestor has submitted a copy of the USPS signed certified green card. This is deemed convincing evidence of carrier receipt of the request for reconsideration.

- The carrier has disputed the diagnosis of and treatment for Depression. The diagnosis codes referenced on the CMS-1500 are 724.4-Lumbar Radiculitis and 553.1-Umbilical Hernia and have not been disputed. CPT code 90801 was billed for the psychiatric diagnostic interview performed as part of a pain management program. Reimbursement is recommended per Rule 134.202(c)(1).

A referral to Legal & Compliance has been made.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §133.307, §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 $194.65 plus accrued interest, due within 30 days of receipt of this Order.

ORDER:

		06/26/07
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.