



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: ACTIVE BEHAVIORAL HEALTHCARE 2420 E RANDOL MILL RD. ARLINGTON, TX 76011	MFDR Tracking #:	M5-07-0374-01 M5-03-2546-01
	DWC Claim #:	
	Injured Employee:	
Respondent Name and Box #: WAUSAU BUSINESS INSURANCE CO BOX 28	Date of Injury:	
	Employer Name:	
	Insurance Carrier #:	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary "Provider sent a request for reconsideration... Proof that carrier received request is also included. Carrier chose not to respond within the 28 day time frame rule."

Principle Documentation:

1. DWC 60 package
2. Medical Bill(s)
3. EOBs
4. Medical Reports
5. Total Amount Sought \$5,010.00*

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "There were no extent issue [sic] for this MDR only. Please advise if you have any additional questions."

Principle Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Dates of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
9-26-02	U-X591 E-X597 D-U301 E-X434 U-X375	90801	\$180.00	\$0.00
9-26-02		90825	\$120.00	\$0.00
11-8-02, 11-22-02, 12-4-02, 12-18-02, 2-19-03, 3-4-03, 3-11-03, 3-25-03		90844	\$960.00	\$0.00
11-8-02, 12-4-02, 12-18-02, 12-27-02, 1-10-03, 1-24-03, 1-31-03, 2-19-03, 4-11-03, 4-21-03		90915	\$1,320.00	\$0.00
12-4-02, 12-18-02, 12-27-02, 1-10-03, 1-24-03, 1-31-03, 2-19-03, 4-11-03, 4-21-03		90900	\$1,200.00	\$0.00
12-4-02, 12-18-02, 12-27-02, 1-10-03, 1-24-03, 1-31-03, 2-19-03, 4-11-03, 4-21-03,		90906	\$1,200.00	\$0.00
2-19-03		90889	\$30.00	\$0.00
Total:				\$5,010.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

1. *In a fax dated 1-9-07 the Requestor sent a revised Table of Disputed services withdrawing services which had been reimbursed by the Respondent. These withdrawn services will not be a part of this review.
2. These services were denied by the Respondent with reason codes:
 - U-X591 Per independent medical exam, no further treatment is necessary
 - E-X597 This is not an accepted Workers' Compensation Claim.
 - D-U301 This item was previously submitted and reviewed with notification of decision issued to payor/provider (Duplicate invoice).
 - E-X434 This case has been controverted
 - U-X375 Unnecessary medical treatment of service
3. The Division has determined that good cause exists to dismiss this request based on: the Requestor no longer operates an active practice at the above address. The Division was unable to contact the Requestor via telephone attempts; the listed phone number(s) have been disconnected. Ricardo Sanchez, who answers the telephone at the new location for this Requestor, states that he is no longer responsible for this dispute. The health care provider has not provided a current, correct address or contact information in accordance with 28 TX. Admin. Code section 102.4 (d) and/or 102.5. Pursuant to Rule 133.307(m)(6) at 28 Texas Administrative Code, 27 Texas Register 12300, this file is dismissed. No further action will be taken.
4. The Division concludes that this dispute was not filed in the form and manner prescribed under Rule 133.307 section (m)(6). As a result, the amount ordered is \$0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code Sections 102.4, 102.5, 134.1, 134.201, 133.307

PART VII: DIVISION DECISION

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 \$0.00 reimbursement.

3-31-09

Donna Auby

Authorized Signature

Medical Fee Dispute Resolution Officer

Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.