



**MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

**PART I: GENERAL INFORMATION**

Requestor's Name and Address:  Integra Specialty Group, P. A. 517 North Carrier Parkway, Suite G Grand Prairie, TX 75050	MFDR Tracking #:	M5-05-2528-01
	DWC Claim #:	
	Injured Employee:	
Respondent Name and Box #:  SERVICE LLOYDS INSURANCE CO BOX 42	Date of Injury:	
	Employer Name:	
	Insurance Carrier #:	

**PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION**

Requestor's Position Summary: "The carrier failed to provide original response EOB's for the dates of service of 5-12-04, 5-19-04 and 6-12-04. Also the carrier failed to provide any request for reconsideration EOB's for the outstanding dates of service."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - \$2460.20
3. CMS 1500(s)
4. EOB(s)

**PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION**

No Position Summary submitted.

Principle Documentation:

1. Response to DWC 60

**PART IV: SUMMARY OF FINDINGS**

Date(s) of Service	CPT Code(s) and Calculations	Part V Reference	Amount in Dispute	Amount Due
5-12-04, 6-12-04	99080-73 (\$15.00 x 2)	1	\$30.00	\$30.00
8-12-04 – 1-7-05	99080-73 (\$15.00 x 5)	3, 4	\$75.00	\$75.00
6-21-04 – 6-25-04	97545-WH (\$102.40 x 6 days)	2, 5	\$614.40	\$614.40
6-21-04 – 6-25-04	97546-WH (\$51.20 hr. x 6 hours)	2, 5	\$1740.80	\$1740.80
<b>Total Due:</b>				<b>\$2,460.20</b>

**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.

Through submission of a Revised Table of Disputed Services on 9-5-07 the Requestor withdrew all services except the Work Hardening Program and the Work Status Reports (99080-73). These withdrawn services will not be a part of this review.

1. Neither the Respondent nor the Requestor provided EOB's for these services. The Requestor submitted convincing evidence of carrier receipt for "Request for EOBs" in accordance with 133.307 (e)(2)(B). This review will be according to Rule 134.202.
2. These services were denied by the Respondent with reason code "A-Preauthorization Required/Not Requested."
3. These services were denied by the Respondent with reason code "169-Disallowed due to physician advisor review," "150-Denied per insurance carrier decision," and/or "V-Unnecessary treatment (with peer review)."
4. The DWC-73 is a required report per Rule 129.5 and cannot be denied for medical necessity. Medical Dispute Resolution has jurisdiction in this matter. Recommend reimbursement per Rule 129.5(i).
5. Per Rule 134.600 (h) the Requestor provided a copy of a Preauthorization Letter (#79513298-1, no date on Preauthorization Letter) for 25 sessions of Work Hardening Program. The Preauthorization Letter stated: "O.K. extension of time granted to end by 7-3-04."
6. Per review of Box 32 on CMS-1500, zip code 75050 is located in Dallas County. The maximum reimbursement amount, under Rule 134.202(b), is determined by locality.

A Legal and Compliance referral has been made for inappropriate denial of the preauthorized service per Rule 134.600 (c)(1)(B).

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES**

Texas Labor Code Sec. §413.011(a-d)  
28 Texas Administrative Code Sec. §129.5, §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 reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of \$1,188.58 plus accrued interest, due within 30 days of receipt of this Order.

**ORDER:**

7-6-07

Authorized Signature

Medical Fee  
Dispute Resolution  
Officer

Date

**PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW**

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.**