



## MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

### PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> <input checked="" type="checkbox"/> Health Care Provider <input type="checkbox"/> Injured Employee <input type="checkbox"/> Insurance Carrier	
Requestor=s Name and Address:  Integra Specialty Group, P. A. 517 North Carrier Parkway, Suite G Grand Prairie, TX 75050	MDR Tracking No.: M5-07-0598-01 Previous Tracking No.: M4-06-6216-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name:  DALLAS NATIONAL INSURANCE CO, BOX 20	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

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

Requestor's Position Summary states in part, "...The carrier failed to provide the original response EOB's for the outstanding dates of service...Also, the carrier failed to provide any request for reconsideration response EOB's for the outstanding dates of service."

Principle Documentation:

1. DWC 60 package
2. CMS 1500's
3. EOB's

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

Respondent's Position Summary states in part, "...Carrier used Division-approved codes for its denial/reduction of reimbursement and Carrier used sufficient language in its denial to place Requestor on notice of the reasons for its denial/reduction. Finally, Carrier provided a sufficient response to Requestor's request for reconsideration..."

Principle Documentation:

1. DWC 60 package
2. CMS 1500's
3. EOB's

**PART IV: SUMMARY OF DISPUTE AND FINDINGS**

Date(s) of Service	Denial Code	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
11-4-05	B12, 880-144	97032 (\$20.20 MAR x 2 units)	1	\$40.40
11-4-05	B12, 880-144	97035	1	\$15.59
11-4-05	B12, 880-144	97112	1	\$38.15
11-4-05	B12, 880-144	97140	1	\$34.13< MAR
11-4-05	B12, 880-144	99213	1	\$68.24< MAR
11-11-05 – 11-30-05	62, 880-107	97032 (\$20.20<MAR x 14 units)	2	\$282.80
11-11-05 – 11-30-05	62, 880-107	97035 (\$15.59 x 7 units)	2	\$109.13
11-11-05 – 11-30-05	62, 880-107	97112 (\$38.15 x 7 units)	2	\$267.05
11-11-05 – 11-30-05	62, 880-107	97140 (\$34.13<MAR x 7 units)	2	\$238.91
11-11-05 – 11-30-05	62, 880-107	99213 (\$68.24<MAR x 7 DOS)	2	\$477.68
11-28-05 – 11-30-05	62, 880-107	97110 (\$36.14 x 8 DOS)	2	\$289.12
	Total Due			\$1,861.20

**PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION**

In a letter dated 1-29-07 the Requestor withdrew services which were denied for medical necessity. On 1-12-07 Medical Dispute Resolution submitted a Notice to Requestor to submit additional documentation necessary to support the charges and to challenge the reasons the Respondent had denied reimbursement within 14 days of the Requestor's receipt of the Notice.

1. These services were denied by the Respondent as "B12-Services not documented in patients medical records," and "880-144-Payment denied pending receipt of corresponding medical records." The Requestor did provide documentation to support delivery of services per Rule 133.307(g)(3)(A-F) and documentation per 133.301(c) and (d). Recommend reimbursement per Rules 134.202(c)(1) and (d)(2).
2. These services were denied by the Respondent as "62-Payment denied/reduced for absence of, or exceeded, pre-certification/authorization" and "880-107-Denied per insurance: pre-authorization was not requested." Per Rule 134.600 physical therapy and office visits for this date of service do not require preauthorization. Recommend reimbursement per Rules 134.202(c) (1) and (d) (2).

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

Texas Labor Code 413.011(a-d), 413.031  
28 Texas Administrative Code Sec. 133.301, 133.307, 134.1, 134.202, 134.600

**PART VII: DIVISION DECISION AND 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 in the amount of \$1,861.20. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30-days of receipt of this Order.

Ordered by:

02-23-07

Authorized Signature

Typed Name

Date of Order

**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.**