



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: <p style="text-align: center;">Integra Specialty Group, P.A. 517 North Carrier Parkway, Ste G Grand Prairie, TX 75050</p>	MFDR Tracking #: M5-08-0036-01 (current MDR #) M4-05-9427-01 (former MDR #)
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: <p style="text-align: center;">Texas Mutual Insurance Company Rep Box # 54</p>	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 only four of the outstanding dates of service: 4/06/05, 4/15/05, 4/22/05, and 4/28/05. However, 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. Total Amount Sought -\$3,705.37 *
3. CMS 1500(s)
4. EOB(s)

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: No position summary was received from the Respondent

Principle Documentation: No response to the DWC-60 was received from the Respondent

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Code(s) and Calculations	Denial Code(s)	Part V Reference	Amount Ordered
10-06-04	97124	F/435	1 & 3	\$00.00
10-6-04 to 12-28-04 (except DOS 11-23-04)	97140	F/434/435	1 & 2	\$00.00
10-15-04, 11-03-04, 12-14-04	95851	F/434/435	1 & 4	\$00.00
10-18-04, 11-16-04, 12-22-04, 12-28-04	95833	F/434/435	1 & 4	\$00.00
11-23-04	97140	F/102	1 & 2	\$00.00

01-03-05 to 01-07-05	97545-WH (\$102.40 x 5 DOS)	N/225	1 & 6	\$512.00
01-03-05, 01-04-05, 01-05-05, 01-06-05 and 01-25-05	97546-WH (\$51.20 x 28 sessions)	N/225	1 & 6	\$1,433.60
04-06-05	99080-73	NO EOB	7	\$15.00
4-15-05, 04-22-05, 4-28-05	97032	NO EOB	5 & 8	\$121.20
4-15-05, 04-22-05, 4-28-05	97035	NO EOB	5 & 8	\$47.52
4-15-05, 04-22-05, 4-28-05	97110	NO EOB	5 & 8	\$332.91
4-15-05, 04-22-05, 4-28-05	99213	NO EOB	5 & 8	\$204.72
04-22-05 & 04-28-05	97140	NO EOB	5 & 8	\$68.26
Total Due				\$2,735.21

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.

* **NOTE:** The medical necessity issues were dismissed per Rule 133.308(r)(7)(8) and (11) due to the Requestor not submitting the IRO fee. These services will not be a part of the review and are not included in the amount sought.

1. These services were denied by the Respondent with the following denial code(s):

- F - Fee guideline MAR reduction
- 435 - The value of this procedure is included in the value of the comprehensive procedure
- 434 - The value of this procedure is included in the value of the mutual exclusive procedure
- 864 - E/M services may be reported only if the patient's condition requires a significant separately identifiable E/M service
- 102 - TWCC has indicated that an exception is granted and an allowance is authorized
- N - Not appropriately documented
- 225 - The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information

2. Per Rule 134.202(b) CPT code 97140 is mutually exclusive to CPT code 97012 also billed on the dates of service in dispute. A modifier is allowed to differentiate between services and separate payment considered. The Requestor did not bill the services with a modifier. No reimbursement is recommended.
3. Per Rule 134.202(b) CPT code 97124 is a component procedure of CPT code 97140 also billed on the date of service in dispute. There are no circumstances in which a modifier would be appropriate. No reimbursement is recommended.
4. Per Rule 134.202(b) CPT code 95851 and CPT code 95833 are component procedures of CPT code 99213 also billed on the dates of service in dispute. There are no circumstances in which a modifier would be appropriate. No reimbursement is recommended.
5. Per review of Box 32 on CMS-1500 zip code 75050 is located in Dallas County. The maximum reimbursement amount, under Rule 134.202(c)(1), is determined by locality.
6. Review of the documentation submitted by the Requestor reveals that the notes support the services billed. Reimbursement is recommended per Rule 134.202(e)(5)(A)(ii) and 134.202(e)(5)(C)(ii).
7. Neither party submitted an EOB for review. Per Rule 133.307(e)(2)(B) the Requestor submitted convincing evidence of the Respondent's receipt of the providers request for an EOB. Reimbursement is recommended per Rule 129.5(i) in the amount of **\$15.00**.

8. Neither party submitted EOBs for review. Per Rule 133.307(e)(2)(B) the Requestor submitted convincing evidence of the Respondent's receipt of the providers request for EOBs. The review is per Rule 134.202. Reimbursement is recommended in the following amounts:

CPT code 97032 - **\$121.20** (1 unit @ \$20.20 x 6 units billed)
 CPT code 97035 - **\$47.52** (1 unit @ \$15.84 x 3 DOS)
 CPT code 97110 - **\$332.91** (1 unit @ \$36.99 x 3 units x 3 DOS)
 CPT code 99213 - **\$204.72** (\$68.24 x 3 DOS)
 CPT code 97140 - **\$68.26** (1 unit @ \$34.13 x 2 DOS)

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311
 28 Texas Administrative Code Sec. §134.1, §134.202, §133.308, §129.5 and §133.307
 Subchapter G, Chapter 2001, Texas Government Code

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, section §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 \$2,735.21 plus applicable accrued interest per Division Rule 134.803, due within 30 days of receipt of this Order.

ORDER:

		12-06-07
_____ 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.