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:	
Integra Specialty Group, P.A. 517 N. Carrier Pkwy. Ste. G Grand Prairie, Tx. 75050	MFDR Tracking #: M4-05-2377-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: AMERICAN HOME ASSURANCE CO.. REP BOX # 19	Date of Injury: Employer Name: Insurance Carrier #: C4210846

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "…The carrier failed to provide an original response EOB for the date of service of 3/3/04. Also, the carrier failed to provide a request for reconsideration EOB for the date of service 3/3/04…."

Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)
3. EOB(s)

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: No position summary submitted to MDR

Principle Documentation:

1. Response to DWC 60
2. EOB copies
3. CMS 1500 copies

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
2-20-04	F & 435 F, O, 435, & 730	95831 95851	1 & 3	$0.00 $0.00
3-3-04	NO EOB	97035 97110 97140	2 & 4 2 & 4 2 & 4	$15.84 $36.99 $34.13
3-22-04	G, O,717, & 730	97010	1 & 5	$0.00
4-5-04	G F, O, 435, & 730	97010 97124	1 & 6 1 & 6	$0.00 $0.00
Total Due:				$86.96

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.

The Requestor submitted an updated Table of Disputed Services on 6-28-07 and that Table will be used in evaluating this review.

1. These services were denied by the Respondent with reason codes:

   O: Denial after Reconsideration
   717: The value of this procedure is included in the value of another procedure performed on this date
   730: Reduction or denial of payment resulting after a reconsideration was completed
   F: Fee Schedule MAR Reduction
   435: The value of this procedure is included in the value of the comprehensive procedure
   G: Unbundling

2. Per review of Box 32 on CMS-1500, zip code 75050 is located in Dallas County.

3. The Respondent submitted an EOB that reflects payment upon reconsideration and a copy of the cleared check in the amount of $56.96 for DOS 2-20-04. The Requestor billed 2 units for each of these CPT codes. The Respondent reimbursed for 1 unit on each of these codes. Per Rule 134.202 (b) the CPT codes billed of 95831 & 95851 are inclusive of code 99213 and are not separately reimburseable. Additional reimbursement is not recommended.

4. CPT codes 97110, 97140, & 97035 are not inclusive within any other CPT code billed for DOS 3-3-04, therefore per Rule 134.202 (b) and (c) (1) payment is recommended.

   - 97110: $29.59 x 125%=$36.99
   - 97035: $12.67 x 125%=$15.84
   - 97140: $27.30 x 125%=$34.13

5. CPT code 97010 for DOS 3-22-04 is a bundled service and considered an integral part of a therapeutic procedure. Regardless of whether it is billed alone or in conjunction with another therapy code, additional payment is never made. Per Rule 134.202 (b) payment is not recommended.

6. CPT code 97010 for DOS 4-5-04 is a bundled code and considered an integral part of a therapeutic procedure. Regardless of whether it is billed alone or in conjunction with another therapy code, additional payment is never made. Per Rule 134.202 (b) payment is not recommended for code 97010. CPT code 97124 for DOS 4-5-04 is a component procedure to CPT code 97140 billed on this same day. Per Rule 134.202 (b) payment is not recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.1, §134.202

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 reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $86.96 plus accrued interest, due within 30 days of receipt of this Order.

ORDER:

Authorized Signature	Medical Fee Dispute Resolution Officer	Date
		7/23/07

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.