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 #: M4-05-3377-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: LUMBERMENS UNDERWRITING ALL. REP. BOX # 19	Date of Injury: Employer Name: Insurance Carrier #: TX 276987

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "...The carrier has failed to provide any original EOBs for the dates of service of 7/3/04, 9/7/04, and 9/8/04. Also, the carrier has failed to provide any request for reconsideration response EOBs for the outstanding dates of service. Instead, the carrier sent a letter dated December 10, 2004 and returned the Request For Reconsideration back to the HCP.…"

Principle Documentation:

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

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "...This dispute involves DOS 07/03/04-09/21/04. Carrier denied payment for bills totaling $984.12 because of a lack of documentation showing that the services were properly performed and related to the compensable injury. Furthermore, a provider must make a timely and valid request for reconsideration before requesting medical dispute resolution. 28 TAC 133.304 (m). The request for reconsideration must include three items: (1) a copy of the original bill, with the identical codes and charges as the original bill, and clearly marked with the statement: "REQUEST FOR RECONSIDERATION"; (2) a copy of the carrier's original explanation of benefits; and (3) a claim-specific substantive explanation of the provider's position. 28 TAC 133.304 (k) The claim-specific substantive explanation must be more than a mere generic statement such as "insurance carrier improperly reduced the bill." 28 TAC 133.304 (k) (3). In the immediate case the provider has failed to submit any claim-specific substantive explanation with its request for reconsideration. All that was submitted was the original bill stamped "REQUEST FOR RECONSIDERATION" and the EOB. Accordingly, that the request was not complete and fails to satisfy the prerequisite for medical dispute resolution. This matter is not ripe for review and should be dismissed pursuant to 28 TAC 133.307 (m) (3)…."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
7-3-04	NO EOB	99080-73	2 &3	$ 15.00
8-27-04	N & 133	97032 (x2)	1, 2, &4	$ 40.40
8-31-04	N & 133	97750-FC (x16)	1 &5	$ 0.00
9-7-04	NO EOB NO EOB	97140 99213	2 &6 2 &6	$ 34.13 $ 68.24
9-8-04	NO EOB NO EOB	96004 97032 (x2)	2 &6 2 &6	$ 152.75 $ 40.40
9-21-04	N & 116	97032 (x2)	1, 2 &4	$ 40.40
Total Due:				$ 391.32

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.

1. These services were denied by the Respondent with reason code "N(Not Appropriately Documented), "116 (Timed Procedure-Submit treatment time), and "133 (See Additional Information; Per Medicare/LMRP guidelines, timed units of physical medicine must include documentation of the amount of time spent on a cumulative basis. LMRPY-13.3).

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

3. Neither party submitted an EOB that reflects payment for the CPT code of 99080-73 for DOS 7-3-04, therefore pursuant to Rule 129.5 (i) and Rule 133.307 (e) (2) (B) payment is recommended.

    - CPT code 99080-73: MAR=$15.00

4. Upon review of the documentation, the Requestor did document the two timed units of CPT code 97032 for DOS 8-27-04 and 9-21-04, therefore per Rule 134.202 (b) and (c) (1), payment is recommended.

    - CPT code 97032: $16.16 x 125%= $20.20 (x2 units)=$40.40

5. Per review of the documentation, the F.C.E. billed for DOS 8-31-04 (16 units) does not document the stop time, therefore pursuant to Rule 134.202 (b) payment is not recommended.

6. Neither party submitted an EOB for the disputed DOS of 9-7-04 and 9-8-04, therefore per Rule 134.202 (b) and (c) (1) and per Rule 133.307 (e) (2) (B) payment is recommended.

    - CPT code 97140: $27.30 x 125%=$34.13
    - CPT code 99213: $54.59 x 125%=$68.24
    - CPT code 96004: $122.20 x 125%= $152.75
    - CPT code 97032: $16.16 x 125%= $20.20 (x2 units)=$40.40

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.1, §134.202, §129.5

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 $391.32 plus accrued interest, due within 30 days of receipt of this Order.

ORDER / DECISION:

		7/11/07
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

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.