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 #: M4-05-4565-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: HARTFORD UNDERWRITERS INS. REP. BOX # 27	Date of Injury: Employer Name: Insurance Carrier #: YHZC 36424

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "...The Carrier failed to provide any original response EOBs for the dates of service of 5/11/04, 5/14/04, and 5/21/04. Also, the Carrier failed to provide any request for reconsideration EOBs for the outstanding dates of service…."

Principle Documentation:

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

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: Position summary not submitted to MDR.

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
5-11-04	NO EOB	97032 99204	2 &3 2 &3	$ 20.20 $ 174.91
5-14-04	NO EOB	97032 99213	2 &3 2 &3	$ 20.20 $ 68.24
5-21-04	NO EOB	97140 99213	2 &3 2 &3	$ 34.13 $ 68.24
6-04-04	F D	97250 99213	1 &5 1, 2, & 4	$ 0.00 $ 68.24
11-19-04	NO CODE LISTED	97032 (x 2) 97035 97140 99213	2 &6 2 &6 2 &6 2 &6	$ 40.40 $ 15.84 $ 34.13 $ 68.24
Total Due:				$612.77

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 F (If reduction, then processed according to the Texas Fee Guidelines), F (Reimbursement is being withheld as the procedure code is not recognized according to the 2003Workers' Compensation Commission Fee Schedule. Please rebill using the current year CPT-4 procedure code) and D (Reimbursement was previously made for services rendered to this injured worker on this date of service.)

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

3. Neither Party submitted EOBs for the disputed CPT codes for DOS 5/11/04, 5/14/04, and 5/21/04, therefore per Rule 134.202 (b) and (c) (1) payment is recommended per the MAR.

    - CPT code 97032: $16.16 x 125%= $ 20.20
    - CPT code 99204: $139.93 x 125%= $ 174.91
    - CPT code 99213: $54.59 x 125%= $ 68.24
    - CPT code 97140: $27.30 x 125%= $ 34.13

4. The Respondent did not submit an EOB for the disputed CPT code of 99213 for DOS 6-4-04, therefore per Rule 134.202 (b) and (c) (1) payment is recommended per the MAR.

    - CPT code 99213: $ 54.59 x 125%= $ 68.24

5. CPT code 97250 submitted by the Requestor for DOS 6-4-04 is not a valid CPT code per Rule 134.202 (b); therefore no review was conducted.

6. Requestor's EOB submitted for DOS 11-19-04 reflects that payment was denied for "Reimbursement is being withheld as date of service is after the closed date on this claim." Respondent did not submit an EOB for the disputed CPT codes for DOS 11-19-04, therefore per Rule 134.202 (b) and (c) (1) payment is recommended.

    - CPT code 97032: $16.16 x 125%= $ 20.20 (x2)
    - CPT code 97035: $12.67 x 125%= $ 15.84
    - CPT code 97140: $27.30 x 125%= $ 34.13
    - CPT code 99213: $54.59 x 125%= $ 68.24

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 $612.77 plus accrued interest, due within 30 days of receipt of this Order.

ORDER / DECISION:

		7-2-07
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.