Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: Integra Specialty Group, P. A. 517 North Carrier Parkway, Suite G Grand Prairie, TX 75050	MFDR Tracking #: M4-05-6819-01 Previous Tracking #: M4-05-6618-01 DWC Claim #: Injured Employee:
Respondent Name: AMERICAN HOME ASSURANCE CO Box #: 19	Date of Injury: Employer Name: VOUGHT AIRCRAFT INDUSTRIES INC Insurance Carrier #: 710038910

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: The carrier failed to provide original EOB for date of service 11-11-04. The 11-17-04 EOB did not include the charges and reason for denial…Also, the Carrier failed to provide any request for reconsideration 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 POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary (Table of Disputed Services): "…The D&O provided by the Requestor does not specify the nature of the compensable cervical injury, and does not expressly include the bill injury, brachia neuritis or radiculitis (723.4).

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and/or Description	Part V Reference	Amount Due
11-11-04	No EOB, E, or F	97012 ($19.21 x 16 units)	1, 2, 3, 4, 5, 6	$307.36
11-11-04	No EOB, E, or F	97032 ($20.20 x 36 units)	1, 2, 3, 4, 5, 6	$727.20
11-11-04 – 12-11-04	E, F	99080 -73 ($15.00 x 2)	1, 3, 4, 5, 6	$30.00
11-11-04	No EOB	99204	1, 2, 3, 4, 5, 6	$174.91
11-15-04	E, F	95851 (global to 99213)	1, 3, 4	$0.00
11-15-04	E, F	95852 (global to 99213)	1, 3, 4	$0.00
11-15-04 – 12-30-04	E, F	96004 ($152.75 x 6 units)	1, 3, 4, 5, 6	$916.50
11-15-04 – 1-6-05	No EOB, E, or F	97110 ($36.99 x 46 units)	1, 2, 3, 4, 5, 6	$1,701.54
11-15-04	No EOB, E, or F	99213 ($68.24 x 19 DOS)	1, 2, 3, 4, 5, 6	$1,296.56
11-17-04	E, F	95832 (global to 99213)	1, 3, 4	$0.00
11-17-04	No EOB, E, or F	95833 (global to 99213)	1, 2, 3, 4	$0.00
11-11-04 – 1-6-05	No EOB, E, or F	97140 (global to 97012 except below)	1, 2, 3, 4	$0.00
11-23-04, 11-29-04, 12-16-04, 12-21-04	E, F	97140 ($34.13 x 4 units)	1, 3, 4, 5, 6	$136.52
11-22-04 – 1-6-05	E, F	97035 ($15.84 x 8 units)	1, 3, 4, 5, 6	$126.72
Total Due:				$5,417.31

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.

1. These services were denied by the Respondent with reason codes "E-Extent" and "F-Fee guideline MAR reduction," or no EOBs were received from either party.

2. Neither the Respondent nor the Requestor provided EOBs for many of the services. The Requestor submitted convincing evidence of carrier receipt for "Request for Reconsideration EOBs" in accordance with 133.307 (e)(2)(B).

3. In a Benefit Review Conference held on 2-28-06, the parties agreed that the compensable injury of 10-13-04 extends to include bilateral carpal tunnel syndrome. Diagnosis code "354.0 – Carpal Tunnel Syndrome" was billed by the Requestor.

4. Diagnosis code "723.4 - Brachial Neuritis or Radiculitis –Not Otherwise Specified" was also billed by the Requestor. This diagnosis has never been disputed by the Respondent as not compensable.

5. Per review of Box 32 on CMS-1500, zip code 75320 is located in Dallas County.

6. Reimbursement is recommended per Rule 134.202(c)(1).

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

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

PART VII: DIVISION DECISION AND/OR 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 $5,417.31 plus accrued interest, due within 30 days of receipt of this Order.

Decision:

		7-11-07
	Medical Fee Dispute Resolution Officer	
		7-11-07
Authorized Signature	Manager, Medical Fee Dispute Resolution	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.