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 #: M4-05-8471-01 DWC Claim #: Injured Employee:
Respondent Name: American Home Assurance Co. Box #: 19	Date of Injury: Employer Name: HARRISON QUALITY CONSTRUCTION Insurance Carrier #: 710007442

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "The carrier failed to provide an original response EOB's (sic) for the dates of service 09/30/05, 10/05/05, 01/14/05 (TWCC 73 Report). Also, the carrier failed to provide any request for reconsideration EOB's."

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: "The carrier asserts that it has paid according to applicable fee guidelines and/or reduced to fair and reasonable."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and/or Description	Part V Reference	Amount Due
09/30/04 & 10/05/04	No EOBs	97545-WH	1, 3	$204.80
09/30/04 & 10/05/04	No EOBs	97546-WH	1, 2, 4	$614.40
11/04/04 – 1/14/05	No EOBs	99080-73	5	$15.00
Total Due:				$834.20

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. On April, 13, 2007, the Requestor submitted an updated Table of Disputed Services, which will be used for this review.

2. In a letter dated April 13, 2007, the Respondent clarified that the pre-authorization start date should be 09/30/04.

3. CPT code 97545-WH was billed for dates of service 09/30/04 & 10/05/04. EOBs were not submitted by either party to the Dispute. Per Rule 133.307 (e) (2) (B), the Requestor submitted convincing evidence of their request for EOBs in the form of a Returned Receipt Request signed by an agent for the Respondent. Requestor received Pre-Authorization for work hardening for dates 09/30/04 through 12/21/04 under Pre-Auth 017668901 on 09/24/04. Per Rule 134.202(e) (5) (A) (ii), a Non-CARF accredited program shall be reimbursed at 80% of the MAR. Per Rule 134.202 (5) (c) (i), the first two hours of each session shall be billed and reimbursed as one unit. Reimbursement is recommended in the amount of **$204.80 ($64.00 x 80% = $51.20 (MAR) X 4 (2 Units) = $204.80.**

4. CPT code 97546-WH was billed for dates of service 09/30/04 & 10/05/04. EOBs were not submitted by either party to the Dispute. Per Rule 133.307 (e) (2) (B), the Requestor submitted convincing evidence of their request for EOBs in the form of a Returned Receipt Request signed by an agent for the Respondent. Requestor received Pre-Authorization for work hardening for dates 09/30/04 through 12/21/04 under Pre-Auth 017668901 on 09/24/04. Per Rule 134.202(e) (5) (A) (ii), a Non-CARF accredited program shall be reimbursed at 80% of the MAR. Reimbursement is recommended in the amount of $**614.40 ($64.00 x 80% = $51.20 (MAR) X 6 (Units) = $307.20 X 2 (DOS) = $614.40.**

5. CPT code 99080-73 billed for date of service 1/14/05: an EOB was not submitted by either party to the Dispute. Per Rule 133.307 (e) (2) (B), the Requestor submitted convincing evidence of their request for an EOB in the form of a Returned Receipt Request signed by an agent for the Respondent. Per rule 129.5(i), payment is recommended in the amount of **$15.00.**

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.1, §134.202, 133.307, 129.5

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 **$834.20** plus accrued interest, due within 30 days of receipt of this Order.

Decision & Order

	Eileen V. Atkinson	04/24/07
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.