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, Texas 75050	MFDR Tracking #: M4-05-A176-01 DWC Claim #: Injured Employee:
Respondent Name: American Casualty Company Box #: 47	Date of Injury: Employer Name: Manpower Inc. Insurance Carrier #: 215918X1

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: The Requestor did not submit a position summary to MDR

Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)
3. EOB(s)
4. Copy of preauthorization

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: The Respondent did not submit a position summary to MDR

Principle Documentation: None submitted to MDR by Respondent

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and/or Description	Part V Reference	Amount Due
01-27-05 & 02-03-05	G	97140	1-3	$0.00
03-16-05 & 03-17-05	M & F	97546-WH (1 hour @ $64.00 X 6 hours X 80% X 2 DOS minus payment)	4 -7	$512.00
04-13-05	NO EOB	99080-73	8 & 9	$15.00
Total Due:				$527.00

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. The Requestor denied the service(s) for denial reason "G" (unbundling).

2. Per Rule 134.202(b) CPT code 97140 is mutually exclusive to CPT code 97012 also billed for the dates of service in dispute. A modifier is allowed to differentiate between the services and separate payment for the services may be considered if a modifier is used appropriately. The Requestor did not bill with a modifier.

3. No reimbursement is recommended.

4. The Requestor denied the service(s) for denial reason "M" (No MAR) and "F" (Fee Guideline MAR reduction).

5. The Respondent has made a payment of $102.40.

6. The Requestor obtained preauthorization for the service(s) (preauthorization number FLOR03092005002) prior to the services being provided.

7. Additional reimbursement is recommended per Rule 134.202(e)(5)(A)(ii) in the amount listed above.

8. Review of the service billed revealed that neither party submitted an EOB. The Requestor submitted convincing evidence per Rule 133.307(e)(2)(B) that the Respondent was in receipt of the Requestor's request for an EOB. The service will be reviewed per the Medical Fee Guideline.

9. Reimbursement is recommended per Rule 129.5(i) in the amount listed above.

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 and 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 $527.00 plus accrued interest, due within 30 days of receipt of this Order.

Decision and Order by:

		04-04-07
Authorized Signature	Medical Fee Dispute Resolution Officer	Date of Decision and Order

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.