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-A717-01 DWC Claim #: Injured Employee:
Respondent Name and Box #:	Date of Injury:
TEXAS MUTUAL INS. CO.	Employer Name:
REP. BOX # 54	Insurance Carrier #: 99D0000354087

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary "…The carrier has failed to provide an original EOB for the outstanding date of service: 4-16-05. Also, the carrier has 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)
4. Medical Records

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "…The carrier denied the charges in dispute based on Medicare local coverage determination. (LCD) 1-12-05 and 1-28-05; code 97140. This charge was denied per the National Correct Coding Edit. Review of the documentation reveals the Requestor documented manual therapy techniques (97140) and mechanical traction (97012) to the neck & lumbar. The Requestor did not report the CPT code that most comprehensively described the service performed. The service billed, 97140, is a component of code 97012. It is the carrier's position that no reimbursement is due for code 95833 per the CCI edits. Code 95833 is a component of code 99213, also billed on the same DOS. (2-1-05) The carrier has not received, reduced, or denied a charge for code 97799 for DOS 2-23-05. The Requestor included a copy of a green card which they allege was the request for reconsideration for unidentified DOS. It appears the carrier may have returned the request for reconsideration due to a missing or invalid EOB. The Requestor reported that 3 sessions of C.P. Program were approved for DOS 4-8-05 thru 4-15-05…."

Principle Documentation:

1. Response to DWC 60
2. EOB's
3. Position Summary

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
01/12/05	434, W4, 97, 891	97140	1	$ 0.00
1/28/05	434, W4, 97, 891	97140	1	$ 0.00
2/01/05	435, W4, 97, 891	95833	1	$ 0.00
2/23/05	NO EOB	97799-CP	2	$ 0.00
Total Due:				$ 0.00

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, set out the reimbursement guidelines.

On 6-20-07, the Requestor submitted an updated Table of Disputed Service and that will be used for this review.
The Respondent denied with payment exception codes 434 (The value of this procedure is included in the value of the mutual exclusive procedure), 435 (The value of this procedure is included in the value of the comprehensive procedure), 97 (Payment is included in the allowance for another service/procedure), W4 (No additional reimbursement allowed after review of appeal/reconsideration) and 891 (The insurance company is reducing or denying payment after reconsidering a bill.)

1. Per Rule 134.202 (b), CPT code 97140 for DOS 1-12-05 & 1-28-05 is a mutually exclusive procedure to CPT code 97012 and does not warrant separate payment. CPT code 95833 for DOS 2-1-05 is a component of CPT code 99213 and does not warrant separate payment, therefore payment is not recommended.

2. Neither party submitted an EOB for DOS 2-23-05; Rule 133.307 (e) (2) (B). The Pre-Authorization letter attached from the Requestor indicates the Chronic Pain program did not receive authorization until 2-24-05, therefore per Rule 134.600 (h) (10) (B) the disputed DOS of 2-23-05 is not recommended for payment.

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

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.1, §134.202, §134.600, §133.307

PART VII: DIVISION DECISION

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 not entitled to reimbursement.

DECISION:

Authorized Signature	Medical Fee Dispute Resolution Officer	7-02-07 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.