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:	MFDR Tracking #: M4-05-B428-01
Integra Specialty Group, P.A. 517 N. Carrier Pkwy. Ste. G Grand Prairie, Tx. 75050	DWC Claim #:
	Injured Employee:
Respondent Name and Box #:	Date of Injury:
ST. PAUL FIRE & MARINE INS.	Employer Name:
REP. BOX # 05	Insurance Carrier #: 039CBVER7624

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "…The carrier failed to provide the original response EOBs for the outstanding dates of service of 4/08/05 and 4/29/05. Also, the carrier failed to provide any request for reconsideration EOBs 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: Position summary not submitted to MDR.

Principle Documentation:

1. Copies of Medical Records
2. Copies of EOBs
3. Payment Screens/Cleared checks

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
10-5-04	G & 97	97124	1 & 3	$0.00
10-11-04	G	97140	1 & 4	$0.00
10-22-04	G	97140	1 & 4	$0.00
10-28-04	G	97140	1 &4	$0.00
11-1-04	A A	97545-WH 97546-WH	1 & 4 1 & 4	$0.00 $0.00

11-5-04	A A	97545-WH 97546-WH	1 & 4 1 & 4	$0.00 $0.00
11-10-04	A A	97545-WH 97546-WH	1 & 4 1 & 4	$0.00 $0.00
2-24-05	G	97140	1 & 4	$0.00
3-22-05	G	97140	1 & 4	$0.00
4-8-05	NO EOB RECEIVED	99080-73	4	$0.00
4-29-05	NO EOB RECEIVED	97140 97750-FC(x8)	4 4	$0.00 $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.

1. These services were denied by the Respondent with reason code "A (Preauthorization required but not requested), "G (Unbundling) and "97 (Payment is included in the allowance for another service/procedure).

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

3. CPT code 97124 for DOS 10-5-04 is a component procedure to CPT code 97140 billed on this same day. Per Rule 134.202 (b) payment is not recommended.

4. The Respondent has submitted payment screens and copies of cleared checks for the remaining DOS in dispute of 10-11-04 thru 4-29-05 as proof of payment. Per Rule 134.202 (b) payment is not recommended.

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 not entitled to reimbursement for the services involved in this dispute.

DECISION:

		7/23/07
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.