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

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address: Integra Specialty Group, P.A. 517 North Carrier Parkway, Ste. G Grand Prairie, TX 75050	MDR Tracking No.: M4-07-0449-01 Claim No.: Injured Employee's Name:
Respondent's Name: American Zurich Insurance Co. Rep. Box # 19	Date of Injury: Employer's Name: Dixie Staffing Services Insurance Carrier's No.: 001627023533WC01

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary as listed on the Table of Disputed Services: "99212 – No EOB Received; 97545WH and 97546WH – Pre-authorized #1698553/Per MAR Fee Guidelines."

Principle Documentation: 1. DWC 60 package
2. CMS 1500's
3. Explanation of Benefits (EOBs)
4. Medical Reports

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary states in part, "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 DISPUTE AND FINDINGS

Date(s) of Service	Denial Code	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
4-10-06	No EOB	99212	2-6	$48.99
6-7-06	M	97545-WH	1-2, 4, 5, 7	$81.92
	M	97546-WH (6 units)		
TOTAL DUE				$130.91

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Section 413.011(a-d) titled (Guidelines and Medical Policies), and Division Rule 134.202 titled (Medical Fee Guideline) effective August 1, 2003, sets out reimbursement guidelines.

1. This dispute relates to procedures/services that were billed under CPT codes 97545-WH and 97546-WH that were denied/reduced reimbursement by the insurance carrier based upon: "M – Payment recommended at fair and reasonable rate."

2. The Requestor complied with Rule 133.304 by submitting medical bills for reconsideration.

3. Neither party submitted an EOB for CPT code 99212. The Respondent did not comply with Rule 133.307(e)(3) by submitting the missing EOBs. The Requestor submitted convincing evidence, a signed certified green card, to support position that CMS-1500 was submitted for audit. Since the insurance carrier did not raise the issue in their response that

they had not had the opportunity to audit these bills and did not submit copies of the EOBs, the Medical Dispute Resolution Division will review these services per *Medical Fee Guideline (MFG).*

4. Per Rule 133.307(d), the request for medical dispute resolution was received in the Division on 9-20-06.

5. Based on Division Rule 133.307(d)(1-2), the only dates of service eligible for review are those commencing on 4-10-06 and extending through 6-7-06.

6. Per CMS-1500, the zip code 75050 is located in Dallas County. The MFG MAR for CPT code 99212 in Dallas County is $50.23 or less per Rule 134.202(d)(2). Per the Table of Disputed services, the Requestor is seeking medical dispute resolution for $48.99, this amount is recommended.

7. On 5-19-06, the Requestor obtained preauthorization approval for 10 visits of work hardening to be performed from 5-16-06 and end by 7-16-06. Therefore, the disputed work hardening program was preauthorized. Per Rule 134.202(e)(5)(A)(ii) and (e)(5)(C), the Requestor is entitled to reimbursement of 80% of $64.00/hr = $51.20/hr. This amount X 8/hrs = $409.60. The Respondent paid $327.68. The difference between MAR and amount paid = $81.92.

Therefore it is the conclusion of the Medical Dispute Resolution that additional reimbursement in the amount of $130.91 is due the Requestor.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 413.011(a-d)
28 Texas Administrative Code Sec. §134.1
28 Texas Administrative Code Sec. §134.202
28 Texas Administrative Code Sec. §133.304
28 Texas Administrative Code Sec. §133.307

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 additional reimbursement in the amount of **$130.91.** The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30-days of receipt of this Order.

Ordered by:

	Elizabeth Pickle, RHIA	January 5, 2007
Authorized Signature	Typed Name	Date of 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.