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's Name and Address: Integra Specialty Group, P. A. 517 North Carrier Parkway, Suite G Grand Prairie, TX 75050 – 5464	MFDR Tracking #: M4-07-1148-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: POLY AMERICA INC. Box 11	Date of Injury: Employer Name: POLY AMERICA LP Insurance Carrier #: PA010058

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "Attached you find a copy of all documents relevant to these transactions including; the RFR Position Statement, a chart of disputed items, proof carrier received request for Reconsideration, original response EOBs received, relevant HCFA forms, carrier request for reconsideration response EOBs relevant SOAP notes, and other relevant documentation."

Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)
3. EOB(s)

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

No response was received from the Respondent.

PART IV: SUMMARY OF FINDINGS

Review of the box 32 on CMS-1500, revealed zip code 75050 is located in Dallas County.

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
10-31-05 – 11-8-05	No EOBs	97032 ($20.20<MAR x 6 units)	1, 2	$121.20
10-31-05 – 11-8-05	No EOBs	97110 ($36.14 x 12 units)	1	$433.68
10-31-05 – 11-8-05	No EOBs	97112 ($38.15 x 3 units)	1	$114.45
10-31-05 – 11-8-05	No EOBs	97140 ($34.13<MAR x 3 units)	1, 2	$102.39
10-31-05, 11-8-05	No EOBs	99213 ($68.24<MAR x 3 DOS)	1, 2	$136.48
1-10-06	No EOBs	99212 ($48.99<MAR x 1 DOS)	1, 2	$48.99
1-23-06 -2-15-06	50	97545-WH ($102.40 x 15 days)	3, 4, 5	$1,536.00
1-23-06 -2-15-06	50	97546-WH($51.20 hr. x 90 hours)	3, 4, 5	$4,608.00
Total Due:				$7,101.19

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. Neither the Respondent nor the Requestor provided EOBs for these services. The Requestor submitted convincing evidence of carrier receipt for "Request for Reconsideration EOBs" in accordance with 133.307 (e)(2)(B). There was convincing evidence of insurance carrier receipt of request for EOB per 133.307(g)(3)(a). Reimbursement per 134.202(d)(2) is recommended.

2. Per Rule 134.202(d), "reimbursement shall be the least of the (1) MAR amount as established by this rule or, (2) the health care provider's usual and customary charge."

3. The Respondent denied these services as "50-These are non-covered services because this is not considered a 'Medical Necessity" by the Payer."

4. Per Rule 134.600 (h), the Requestor provided a copy of a negotiated preauthorization approval letter dated 1-23-06 for 15 sessions of a work hardening program. The Respondent denied these sessions for unnecessary medical treatment based on a peer review. Rule 133.301 (a) states "the Respondent shall not retrospectively review the medical necessity of a medical bill for treatments (s) and/or service (s) for which the health care provider has obtained preauthorization under Chapter 134 of this title."

5. Per Rule 134.202(e)(5)(A)(ii) reimbursement for non-CARF accredited Programs shall be 80% of $64.00 per hour.

A Legal and Compliance referral has been made for inappropriate denial of the preauthorized service per Rule 133.301(a).

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §133.307, §133.301, §134.1, §134.202, §134.600

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 $7,101.19 accrued interest, due within 30 days of receipt of this Order.

FINDINGS AND DECISION:

	Donna Auby	5-23-07
	Medical Fee Dispute Resolution Officer	
ORDER :	Marguerite Foster	5-23-07
Authorized Signature	Medical Fee Dispute Resolution Team Lead	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.