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 #: M4-07-1426-01 DWC Claim #: Injured Employee:
Respondent Name and Box #:	
POLY AMERICA INC. REP BOX # : 11	Date of Injury: Employer Name: Insurance Carrier #: 463612

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary:

"…..The carrier failed to provide original E.O.B. for date of service 5-3-06. The carrier did provide request for reconsideration response E.O.B. for outstanding DOS. E.O.B. received in response to reconsideration did not list carrier's payment denial reason for non-payment, however, reason presented was "W4; no additional reimbursement allowed after review of appeal. Carrier had the opportunity to dispute 5-3-06 for lack of medical necessity, but did not. Therefore this is only a fee dispute…"

Principle Documentation:

1. DWC 60 package
2. CMS 1500
3. EOB

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

The Respondent did not submit response to DWC 60.

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
5-03-06	W4	97750-FC ($38.61 x 12)	1,2	$444.60
Total Due:				

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. This dispute is related to CPT code 97750-FC x12 units for DOS 5-3-06. Denied with reason code, "W4- no additional reimbursement allowed after appeal. Per Adjuster-Original Denial Still Stands."

2. Per review of Box 32 on CMS-1500, zip code 75050 is located in Dallas County. Reimbursement for CPT code 97750 is $ 463.32. ($ 30.89 x 125%= $38.61 x 12 units.) The Requestor billed $444.60, therefore per Rule 134.202 (d) (2), reimbursement in the amount of $444.60 is 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 entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $444.60 plus accrued interest, due within 30 days of receipt of this Order.

ORDER & DECISION:

Authorized Signature	Medical Fee Dispute Resolution Officer	Date
		7-11-07

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.