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 Name and Address:	MFDR Tracking #:	M4-06-5431-01
Edward F. Wolski, M.D./Wol+Med 2436 I-35 South, Suite 336 Denton, Texas 76205	[redacted]	
Respondent Name and Box #: ALBERTSONS LLC REP BOX # : 19	[redacted]	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENT[redacted]

Requestors' rationale for increased reimbursement states in part, "...We filed a request for reconsideration [redacted] 7/1/05 on 11/23/2005. The carrier did not pay nor acknowledge CPT codes 97110 or 97530 even though they were submitted with the corrected codes...."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $206.16
3. CMS 1500s
4. EOBs

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondents' Position Summary dated May 11, 2007, states in part, "...Carrier maintains that the medical bills for the DOS in question were never properly submitted to the Carrier originally, and therefore, they were not properly submitted for reconsideration. The Provider's original billing to the Carrier failed to include the provider's Tax ID number. The bill was returned to the Provider as an incomplete submission which could not be processed. This requires that the provider submit the billings again as if it had never been submitted before. Due to the defective first submission, there was no EOB generated, so the 'request for reconsideration' was faulty as it was premature. Upon receiving the notice that the tax ID was missing, the provider should have submitted the billing to the carrier again, as a compete medical bill, which would have triggered the Carrier's initial timeframe for response to the completed medical bill. This was never done, so the 'request for reconsideration' was out of line as well. Once the provider received the carrier's response from the original submission of a complete bill, the provider could have requested reconsideration with an EOB attached. The Provider failed to follow the correct procedure in this case, so the Carrier has really never had an opportunity to review a complete bill for DOS 7/1/2005 initially, on request for reconsideration. The request for MRD is premature and should be dismissed. As such, the Carrier was never able to take final action on the bills and the dispute is now improperly before the Division...."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Part V Reference	Amount in Dispute	Amount Ordered
7/1/2005	97110	1 thru 9	$100.70	$00.00
7/1/2005	97530	1 thru 9	$105.45	$00.00
Total:			**$206.16**	**$00.00**

[redacted]

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.202, titled *Medical Fee Guideline* effective for professional medical services on or after August 1, 2003, set out the reimbursement guidelines.

1. The Medical Fee Dispute Resolution (MFDR) received the DWC-60 on April 24, 2006. The date of service in dispute is 7/1/2005. Under 28 TAC Section 133.307 the dispute was submitted timely and eligible for review.
2. The Division has raised issues in order to administer the dispute process consistent with the provisions of the Labor Code and Division rules.
3. Review of the Concentra letter, dated July 27, 2005, states in part, "The attached bills cannot be processed due to missing information (See Below). Required billing form (the attached bill is missing one or more of the following): HCFA1500 form. All bills must contain the following information (the attached bill is missing one or more of the following): Missing or invalid federal tax ID...Please note that balance due statements cannot be processed... Please return re-billing to the carrier/payor referenced below for proper indexing and processing...."
4. Review of Box 25 of the CMS-1500, dated 11/23/2005 reflects a handwritten Federal Tax ID Number "201151107".
5. Review of Box 31 of the CMS-1500, dated 11/23/2005 reflects the following "Signature on File". According to the DWC-67 instructions, Box 31 should contain the following "Last name, first name, MI, suffix, professional license type code, license number, and jurisdiction of the individual health care provider who rendered the health care or supervised an unlicensed individual providing the health care, and the date the claim is submitted to the IC...." Box 31 was not properly completed by the Requestor.
6. Review of Box 33 of the CMS-1500, dated 11/23/2005 reflects the following "WolMed 1 Denton TX 76205". According to the DWC-67 instructions, Box 33 should contain the following "Billing name of provider/supplier or billing service; address, city, state, ZIP code, and telephone#(R). Box 33 was not properly completed by the Requestor.
7. Review of the request for reconsideration letter dated November 23, 2005, states in part, "This is a request for reconsideration for date of service 07/01/05. We have corrected the claim and added the provider's Tax ID:...." However, no information was submitted by the Requestor to support that Box 31 and Box 33 were corrected as well as Box 25.
8. The MFDR Section has determined that the documentation submitted by, the Requestor was not sufficient to support that the corrected CMS-1500 dated 11/23/2005 was sent for reconsideration in accordance with 28 TAC Section 133.304. In addition, the Requestor's copy of the CMS-1500 submitted to MFDR does not contain the correct information required in Box 31 and 33.
9. Under 28 TAC Section 133.304, the Requestor is not entitled to reimbursement.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section 413.011(a-d), Section 413.031 and Section 413.0311
28 Texas Administrative Code Section 134.1, Section 134.202, 133.307 and 133.304
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined the Requestor is not entitled to reimbursement for the services involved in this dispute.

DECISION:

[redacted]	[redacted]	July 2, 2008
Authorized Signature	Auditor III	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787 Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.
Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.