



**MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION**  
**Retrospective Medical Necessity and Fee Dispute**

**PART I: GENERAL INFORMATION**

<b>Type of Requestor:</b> (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address:  Edward Wolski, M. D. Wol+Med 2436 I 35 East, South, Ste. 336 Denton, Texas 76205	MDR Tracking No.: M5-06-1619-01
	Previous Tracking No.: Previously M4-04-8328-01
	Claim No.:
Respondent's Name and Address:  TX Mutual Insurance Company, Box 54	Injured Employee's Name:
	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

**PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY**

Documents include the DWC 60 package. Position paper (Table of Disputed Services) states, "The carrier incorrectly denied stating that our procedure was not documented. All of our documentation follows TWCC medical fee guidelines and CARF."

**PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY**

Documents included DWC 60 response. Position paper states, "The requestor's documentation does not support reimbursement for a 99215 level office visit."

**PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services**

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
	Requestor withdrew medical necessity services.		

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

In a letter dated 5-11-06 the Requestor withdrew all dates of service except 7-18-03. Therefore, the file contains unresolved medical fee issues only. The Division shall proceed to resolve the medical fee dispute in accordance with Rule 133.307.

CPT code 99215 on 7-18-03 was denied by the carrier as "TG-Documentation does not support the service billed." The requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F). The requestor did comply with this CPT code descriptor which states that there must be two of three of these key components: a comprehensive history, a comprehensive examination or medical decision making of high complexity." Reimbursement of \$103.00 is recommended.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION**

28 Texas Administrative Code Sec. 133.307, 134.202, 1996 MFG

**PART VII: DIVISION DECISION**

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 \$103.00. 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.

Findings and Decision and Order by:

Donna Auby, Medical Dispute Officer

5-12-06

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.**