



MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: 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.: M5-06-1871-01

Claim No.:

Injured Employee's Name:

Respondent's Name and Address:

, Box 45

Date of Injury:

Employer's Name:

Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary, "The claims... were submitted to the carrier for reconsideration. The DOS were either denied or reimbursed inappropriately.... We have included proof that the carrier received our claims for these DOS. We feel the carrier again found reason to unjustly deny payment...."

Principle Documentation:

1. DWC-60/Table of Disputed Service
2. CMS-1500's
3. EOB's

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: "...In review of the dispute packet submitted by the requestor..., the Office determined due to an erroneous audit and out of good faith reimbursement is warranted for dates of service.... An immediate re-audit will be requested and payment plus accrued interest will be allowed...."

Principle Documentation:

1. DWC-60/Table of Disputed Service

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)
7-5-05	W4, B15	99071, 99070	1	\$0.00
7-27-05	152, 510	97110 (2 units @ \$33.56)	2	\$67.12
7-27-05	152, 510	97035	2	\$14.63
8-17-05	18, 59, R1	97110 (2 units @ \$33.56)	3	\$67.12
8-17-05	18, 59, R1	97113 (2 units @ \$38.05)	3	\$76.10
8-17-05	18, 59, R1	97116 (2 units @ \$29.41)	3	\$58.82
8-17-05	18, 59, R1	97530 (2 units @ \$35.15)	3	\$70.30
Total Due				\$354.09

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

In letters dated 8-2-06 and 8-8-06 the Requestor withdrew CPT codes 97035, 97110, 97113, 97032 and 97116 denied for medical necessity. The Requestor states that only dates of service 7-5-05, 7-27-05 and 8-17-05 remain in dispute.

Additional EOB's were received by the Respondent on 8-24-06. However, these EOB's exhibited an audit date of 7-21-06. Per Rule 133.307(j)(2) the Respondent cannot raise new issues after a dispute has been filed with the Division.

1. The Respondent denied these services as "W4-Fee Guideline MAR Reduction," and "B-15 – this procedure is a part of doing business and isn't reimbursed separately." Per the 2002 MFG these services are considered to be bundled with other services performed on that date of service. No reimbursement recommended.
2. The Respondent denied this service as "152-Payment adjusted/undocumented length service," and "510-Payment Determined." The Respondent made no payment of Reimbursement per Rule 134.202 (c). No reference to Medical Necessity was made in this denial code explanation, therefore the Division determined this to be a fee issue related to documentation. The Requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Recommend reimbursement per Rule 134.202.
3. The Respondent denied these services as "18-Duplicate Claim/Service" and "R1-Duplicate Billing." The Respondent made no payment of Reimbursement per Rule 134.202 (c) and submitted no support for this being a "duplicate claim." Recommend reimbursement per Rule 134.202.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code Sec. §413.011(a-d) and 413.031
 28 Texas Administrative Code Sec. §133.1(a)(3)(C)
 28 Texas Administrative Code Sec. §133.307(j)(2)
 28 Texas Administrative Code Sec. §134.1
 28 Texas Administrative Code Sec. §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 additional reimbursement in the amount of \$354.09. 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:

Medical Dispute Officer

10-10-06

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.