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:	MFDR Tracking #: M5-06-1924-01
Edward Wolski, M. D. 2436 I 35 East, South, Ste. 336 Denton, Texas 76205	DWC Claim #:
	Injured Employee:
	Date of Injury:
Respondent Name and Box #:	Employer Name:
American Home Assurance Company Box 19	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary states in part, "The carrier is not consistent with their denial and payments. What CPT code is paid on one claim with a particular ICD-9 code may deny on another claim with the same codes a week later. As our claims were filed correctly and in a timely manner, we expect and are entitled to interest included with the claim payment."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $808.49
3. Incomplete CMS 1500s
4. EOBs

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary states in part, "The current dispute involves charges for services dated 8-27-05 –though 1-06-06. Carrier maintains that it has paid all reasonable, necessary and related charges in accordance with the applicable fee guidelines. See attached EOB's."

Principle Documentation:

1. Response to DWC 60
2. EOBs

PART IV: SUMMARY OF FINDINGS

Dates of Service	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
8-27-05, 9-1-05, 9-7-05, 9-8-05, 9-9-05, 9-14-05, 9-16-05, 9-19-05	97024	G, (DOS 9-16-05 also denied as D)	1	$00.00
9-2-05	97024	F	2	$00.00
1-9-06	97750-FC ($35.51 x 16 units)	62, 172, W1	3	$568.16
1-9-06	90801	62, 172	4	$183.81
Total Due:				$751.97

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 provided on or after August 1, 2003, set out the reimbursement guidelines.

*In an e-mail dated 4-29-08 the Requestor withdrew CPT codes 64999 and 90889. In an e-mail dated 8-14-06 the Requestor withdrew dates of service 9-28-05, 12-19-05 and 12-27-05 which were denied for medical necessity. These services will not be a part of this review.

On 8-15-06 the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the Respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

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1. The Respondent denied these services as "G- This procedure is mutually exclusive to another on this date of service. By clinical practice standards, this procedure should not or cannot be performed in the same treatment period," and "F-Level II certified provider." (Date of Service 9-16-05 was also denied as "D-This item was previously submitted and reviewed with notification of decision issued to payor/provider.") The Requestor was given another opportunity to submit the original CMS 1500's per Rule 133.307 (e)(2)(B). No CMS 1500's were submitted. The Division has can't determine which services were billed in order to ascertain whether or not the services were "mutually exclusive" to another services. The Respondent denied reimbursement based upon duplicate claim/service. The disputed service was a duplicate bill submitted for reconsideration of payment. The Respondent did not provide information/documentation of duplicate payments. Recommend no reimbursement.

2. The Respondent denied these services as "F-The charge for this procedure exceeds the fee schedule or usual and customary allowance." Per the EOB, this service was not billed on this date. No reimbursement recommended.

3. The Respondent denied these services as "62-Payment denied/reduced for absence of, or exceeded pre-certification/ authorization," "172-Payment is adjusted when performed/billed at a provider of this speciality," and "W1-Workers Compensation State Fee Schedule Adjustment." Per Rule 134.600 this service does not require preauthorization. The Provider is on the Division's Approved Doctor List. Recommend reimbursement per Rule 134.202.

4. The Respondent denied these services as "62-Payment denied/reduced for absence of, or exceeded pre-certification/authorization," and "172-Payment is adjusted when performed/billed at a provider of this speciality." Per Rule 134.600 this service does not require preauthorization. The Provider is on the Division's Approved Doctor List. Recommend reimbursement per Rule 134.202.

5. Per review of Box 32 on CMS-1500, zip code 76205 is located in Denton County. The maximum reimbursement amount, under Rule 134.202(b), is determined by locality.

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 Sections 134.1 eff. 10-07-91, amended eff. 5-16-02, 134.202, 134.600 eff. 5-2-06
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 that the Requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $751.97 plus applicable accrued interest per Division Rule 134.803, due within 30 days of receipt of this Order.

ORDER:

		6-3-08
Authorized Signature	Medical Fee Dispute Resolution Officer	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.