



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.:	M5-06-1993-01
	Previous MDR No.:	M4-06-6499-01
	Claim No.:	
Respondent's Name: American Home Assurance Company, Box 19	Injured Employee's Name:	
	Date of Injury:	
	Employer's Name:	
	Insurance Carrier's No.:	

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary states in part, "Dates of service 7-12-05 and 1-12-06 were denied using ANSI codes W9 and W1... In denying these dates of service the carrier has violated Rule 133.301. Retrospective Review of Medical Bills."

Principle Documentation:

1. DWC 60 package
2. CMS 1500's
3. EOBs

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary states in part, "The provider seeks reimbursement for electrodes to a TENS unit which the provider claims is necessary as a part of the TENS unit service. However, based upon the carrier's investigation, the claimant stopped using her TENS unit..."

Principle Documentation:

1. DWC 60 package
2. EOBs

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)
1-12-06	16/none	A4595 (2 units x \$36.01)	1	\$72.02
	Total Due			\$72.02

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

Section 413.011(a-d) titled (Guidelines and Medical Policies), and Division Rule 134.202 titled (Medical Fee Guideline) effective August 1, 2003, set out reimbursement guidelines.

In an e-mail dated 10-12-06 Requestor withdrew dates of service 7-12-05 and 11-12-05 which were denied for medical necessity. On 6-23-06 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.

1. The Respondent denied this service with denial code “16-Claim/service lacks information which is needed for adjudication. The Requestor provided documentation per Rule 133.307(g)(3)(A-F) The Requestor submitted convincing evidence of carrier receipt for “Request for Reconsideration EOB’s” in accordance with 133.307(e)(2)(B). There was convincing evidence of insurance carrier receipt of request for EOB per 133.307(g)(3)(a). Reimbursement per the DMEPOS Fee Schedule is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 413.011(a-d), 413.031
28 Texas Administrative Code Sec. 133.1, 133.307, 134.1, 134.202
DMEPOS Fee Schedule

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 \$72.02. 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:

Authorized Signature

Typed Name

10-27-06

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.