MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (X) Yes ( ) No
Requestor's Name and Address Edward F. Wolski, M.D. 2436 S. I-35 E. Suite 336 Denton, TX 76205	MDR Tracking No.: M4-05-0619-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 19 American Home Assurance Company	Date of Injury: Employer's Name: Wal Mart Stores Inc. Insurance Carrier's No.: C2285150

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
10/03/03	02/25/04	See page 2 for Details		

PART III: REQUESTOR'S POSITION SUMMARY

The carrier has denied services with PEC F and M and no response to Request for Reconsideration.

PART IV: RESPONDENT'S POSITION SUMMARY

No recommendation of further payment towards the amount in dispute of $426.20

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

CPT code 99204 for date of service 10/03/03 was denied with PEC- N. Upon reconsideration, carrier maintained position that documentation does not support office visit. Carrier also states that an initial office visit was billed on 8/11/03 and per AMA's 2003 CPT code book, A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years. The carrier has submitted proof of this healthcare provider billing a previous initial visit, therefore, no reimbursement recommended.

For CPT code A9150 for dates of service 10/9/03, 10/10, 10/11, 10/17, 10/18, 10/21, & 10/31/03 and code A9999 for 10/9/03 the requestor originally billed with code 99070. This code was reviewed and re-reviewed for reconsideration. There are no EOBs showing a review was made for codes A9150 and A9999 nor convincing evidence of carrier receipt for a request for EOBs for code A9150 & A9999 per Rule 133.307 (e)(2)(B). Furthermore, the documentation submitted to support a request for reconsideration supports original code 99070 and not the codes in dispute, A9150 & A9999. Finally, the requestor submitted documentation consisting of redacted EOBs to support amount billed is fair and reasonable. Again, documentation supports code 99070 and not A9150 & A9999. There is no convincing evidence that the requestor submitted original bills for A9150 & A9999 nor convincing evidence of carrier receipt for such bills. No additional payments recommended due to insufficient documentation.

CPT code 97110 for date of service 10/21/03 was reimbursed at MAR per TrailBlazer/Medicare Fee Schedule at $32.64. Per HCFA submitted by requestor, 2 units were billed and only one was paid. Therefore, payment recommended in the amount of $32.64.

CPT code 95851-59 for date of service 10/21/03 was denied as global. The carrier did not identify what the procedure is included in or global to per Rule 133.304 (c); therefore, reimbursement is recommended.

CPT code 95851-59 for date of service 02/25/04 was also denied as global. Upon reconsideration, the carrier specified that the procedure is global to the treating doctor exam performed on the same day. Per AMA's 2004 CPT book, the definition of a Medical Disability Evaluation, or 99455 exam includes- completion of a medical history commensurate with the patient's condition; performance of an examination commensurate with the patient's condition; formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; development of future medical treatment plan; and completion of necessary documentation/certificates and report. Furthermore, per Rule 134.202 (e)(6)(D)((iii)((II)(-b-), the MAR for musculoskeletal body areas shall be as follows: (-b-) If full physical evaluation, with range of motion, is performed: (-1-)…(-2-)… Range of Motion is included in the reimbursement for the treating doctor exam; therefore, no payment recommended.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
10/3/2003	99204	$153.53	$0.00				
10/9/2003	A9150	$23.88	$0.00				
10/9/2003	A9999	$10.56	$0.00				
10/9/2003	A9150	$9.76	$0.00				
10/10/2003	A9150	$23.88	$0.00				
10/11/2003	A9150	$23.88	$0.00				
10/17/2003	A9150	$20.99	$0.00				
10/18/2003	A9150	$20.99	$0.00				
10/21/2003	95851-59	$30.61	$30.61				
10/21/2003	A9150	$23.88	$0.00				
10/21/2003	97110	$32.64	$32.64				
10/31/2003	A9150	$20.99	$0.00				
2/25/2004	95851-59	$30.61	$0.00				
						Total Left Column:	$426.20
						Total Amount Due:	$63.25

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $63.25. 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 20-days of receipt of this Order.

Ordered by:

Authorized Signature	Benita Diaz Typed Name	06-06-05 Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, 7551 Metro Center Drive, Suite #100, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____