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: Edward F. Wolski M.D. – Wol+Med 2436 I-35 East, South, Suite 336 Denton, TX 76205	MFDR Tracking #: M4-05-0993-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: 1 TAC WC SELF INSURANCE FUND	Date of Injury: Employer Name: DENTON COUNTY Insurance Carrier #: 11502322

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "The carrier violated Rule 133.304 (c)."

Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)
3. Partial EOBs

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "The office visits billed separately were included in procedures billed for the same DOS. Under the current fee guidelines, separate reimbursement for these procedures is not appropriate."

Principle Documentation:

1. Response to DWC 60
2. EOBs

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
01/29/04 & 01/30/04	F, 435	97110	1, 2	$00.00
01/29/04 & 01/30/04	F, 435	97113	1, 3	$00.00
02/19/04 & 02/20/04	F, G, 284	97010-59	4	$00.00
05/07/04 & 05/14/04	F, 217, 282	99213 ($61.98 x 2 units)	5, 6	$123.95
Total Due:				$123.95

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

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

On May 30, 2007 the Requestor submitted an updated Table of Disputed Services, which will be used in this dispute Decision.

1. CPT codes 97110, 97113, billed for dates of service 01/29/04 & 01/30/04 were denied by carrier with reason codes "F-Fee guideline MAR reduction", "435 – The value of this procedure is included in the value of the comprehensive procedure".

2. Per Rule 133.202 (b), CPT code 97110 is a component of CPT 97113 billed on the same day. CPT code 97110 is considered to be a component procedure of CPT code 97113. Reimbursement is not recommended.

3. Per Rule 133.202 (b), CPT code 97113 is a component of CPT 97530 billed on the same day. CPT code 97113 is considered to be a component procedure of CPT code 97110. Per Rule 134.202 (b) reimbursement is not recommended.

4. CPT code 97010-59 billed for dates of service 02/19/04 & 02/20/04 was denied with denial code "G – Unbundling", and "284 – No allowance was recommended as this procedure indicates a status "B". Per Rule 134.202 (b) this code is a "Status B" code and separate reimbursement is not allowed, therefore, no additional reimbursement is recommended

5. CPT code 99213 billed for dates of service 05/07/04 and 05/14/04 was denied by carrier with denial codes "217 – The value of this procedures included in the value of another procedure performed on this date" "F – Fee guideline MAR reduction", "284 – No allowance was recommended as this procedure indicates a status "B", and "G – Unbundling".

6. . Per Rule 133.202 (b), CPT code 99213 is not considered a bundled code or a global code. Per review of Box 32 on CMS-1500, zip code 76205 is located in Denton County. Per Rule 134.202 (c) (10), reimbursement is recommended in the amount of **$123.95 ($49.58 x 125% = $61.98 (MAR) x 2 (Units) = $123.95.**

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.1, §134.202

PART VII: DIVISION DECISION AND/OR 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 reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $123.95 plus accrued interest, due within 30 days of receipt of this Order.

ORDER BY:

Authorized Signature	Medical Fee Dispute Resolution Officer	Date

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.