Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestors Name and Address: Edward F. Wolski M.D./Wol+Med 2436 I-35 East, South #336 Denton TX 76205	MDR Tracking No.:	M4-05-2779-01
	Claim No.:	
	Injured Employee's Name:	
Respondent's Name: LUMBERMENS MUTUAL CASUALTY CO Representative Box #42	Date of Injury:	
	Employer's Name:	TETRA PAK INC
	Insurance Carrier's No.:	4650151133

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Position Summary states in part: "…You have failed to respond to our initial billing. We are providing documentation that proves that the claims were received…"

Principle Documentation: 1. DWC 60
2. Position Summary
3. CMS 1500's
4. EOB's

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Position Summary: "…The provider has failed to meet its burden of proof that its charges and the amount requested are "fair and reasonable..."

Principle Documentation: 1. DWC 60 and Position summary
2. Notice of retrospective determination dated 11/19/02

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and/or Description	Part V Reference	Amount Due
2/12/04	No EOB	99213	1	$61.98
TOTAL DUE				$61.98

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

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

The Respondent submitted a Notice of Retrospective Determination dated 11/19/02. This notice is prior to the rendering of the service in dispute and cannot be used to prospectively deny a service which does not require preauthorization. Therefore, this document has no relevance to the service in dispute.

1. No EOB's were submitted for Code 99213, on date of service 2/12/04. Per 28 Texas Administrative Code Sec. §133.307 (e)(2)(B), the Requestor has provided convincing evidence of the carrier receipt of the provider request for an EOB. Therefore, 28 Texas Administrative Code Sec. §134.202, reimbursement in the amount of $61.97 is recommended for this date of service in dispute.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. 413.011(a-d)
28 Texas Administrative Code Sec. §134.1
28 Texas Administrative Code Sec. §134.202
28 Texas Administrative Code Sec. §133.307 (e)(2)(B)

PART VII: DIVISION 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 **$61.98**. 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.

Order:

		7/6/07
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.