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

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestors Name and Address: Edward F. Wolski, M.D./Wol+Med 24361 I-35 East, South, Suite 336 Denton, Texas 76205	MDR Tracking No.: M4-05-2781-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Fireman's Fund Insurance Company C/o Flahive Ogden & Latson Rep Box # 19	Date of Injury: Employer's Name: Pro Group Holdings, Inc. Insurance Carrier's No.: 67099909993

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary states in part, "…The carrier has failed to respond to our initial billing for dates of service 6-3-04; 8-12-04, 8-24-04 and 8-25-04…Date of service 7-26-04 was denied full reimbursement by the carrier using PEC 'C' 'A' and 'K'. We are not on any Worker's Compensation PPOs. We did have pre-authorization for this service and Dr. Wolski is on the ADL. This date was the first date of our Pain Management Program and the pre-authorization number is 126856. All other dates after this were either paid or partial payment was made. These are all incorrect PECs…Dates of service 8-16-04; 8-17-04, 8-18-04; 8-26-04; 8-31-04; 9-1-04; 9-2-04 and 9-3-04 were all reimbursed incorrectly. We are a CARF accredited facility and the MAR for Chronic Pain Management is $125 an hour…The carrier failed to respond to our request for reconsideration…"

Principle Documentation:
1. DWC 60 package
2. CMS 1500s
3. EOBs
4. Letter from First Health representative, Debbie Toler, dated 01/25/05 confirming that Requestor is not a workers' compensation participating member of the Texas Health Network

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary states in part, "…Carrier has denied full reimbursement for the dates of service in dispute, but has made payment in the amount of $6,772.00 already. Carrier has reimbursed properly pursuant to the applicable rules, law, and fee guidelines in place…"

Principle Documentation:
1. Response to DWC 60

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)
06/03/04	No EOBs	90801 (psychiatric diagnostic interview examination)	1	$00.00
07/26/04	C, 397, 287	97799-CP-CA (Chronic Pain Management Program) (5 hours)	2-6	$00.00
08/12/04	No EOBs	97799-CP-CA (Chronic Pain Management Program) (6 hours)	2-6	$00.00
08/16/04	F	97799-CP-CA (Chronic Pain Management Program) (7 hours)	2-6	$00.00
08/17/04	F	97799-CP-CA (Chronic Pain Management Program) (6 hours)	2-6	$00.00

08/18/04	F	97799-CP-CA (Chronic Pain Management Program) (6 hours)	2-6	$00.00
08/24/04	No EOBs	97799-CP-CA (Chronic Pain Management Program) (8 hours)	2-6	$00.00
08/25/04	No EOBs	97799-CP-CA (Chronic Pain Management Program) (6 hours)	2-6	$00.00
08/26/04	F	97799-CP-CA (Chronic Pain Management Program) (8 hours)	2-6	$00.00
08/30/04	F	97799-CP-CA (Chronic Pain Management Program) (8 hours)	2-6	$00.00
08/31/04	F	97799-CP-CA (Chronic Pain Management Program) (8 hours)	2-6	$00.00
09/01/04	F	97799-CP-CA (Chronic Pain Management Program) (8 hours)	2-6	$00.00
09/02/04	F	97799-CP-CA (Chronic Pain Management Program) (8 hours)	2-6	$00.00
09/03/04	F	97799-CP-CA (Chronic Pain Management Program) (8 hours)	2-6	$00.00
TOTAL DUE				$00.00

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, sets out reimbursement guidelines.

The Requestor did submit convincing evidence of carrier receipt for "Request for Reconsideration" in accordance with 133.307(e)(2)(B). Therefore, reimbursement is not recommended

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code, Section 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 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 not entitled to additional reimbursement.

Ordered by:

Authorized Signature	Typed Name	Date of Order
		10/26/06

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.