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

Requestor=s Name and Address: Edward F. Wolski, M.D./Wol+Med 2436 I-35 East, South, Ste 336 Denton, TX 76205	MDR Tracking No.:	M4-05-3968-01
	Claim No.:	
	Injured Employee's Name:	
Respondent's Name: Paccar Inc. Rep Box # 42	Date of Injury:	
	Employer's Name:	Paccar Inc.
	Insurance Carrier's No.:	003960000706710

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary states in part, "…The carrier failed to respond to our request for reconsideration for date of service 04/21/04. The carrier has denied payment for this date using PEC "D", duplicate. This office believes this is not a duplicate and we are requesting a copy of the original EOB denial… We feel we should be reimbursed with interest.."

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 has failed to meet it's burden of proof to establish that it's charges and the amount requested are "fair and reasonable" and comply with Section 413.011 (b) of the Texas Labor Code and commission rules…"

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)
04/21/04	D	99213-Office Visit	1	$61.98
TOTAL DUE				$61.98

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.

1. CPT Code 99213 (Office Visit) for date of service 04/21/04 denied with "D" – This item was previously submitted and reviewed with notification of decision issued to payor/provider (duplicate invoice). Denial Of "D" was incorrect denial of services for a first request for reimbursement of services rendered. Therefore, Per Rule 134.202 (b) reimbursement in the amount of $61.98 ($49.58 x 125% = $61.98) is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

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

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 **$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.

Ordered by:

Authorized Signature	Typed Name	10/02/06 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.