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

Requestor Name and Address: Edward F. Wolski, M.D. / Wol+Med 2436 I-35 E. South Ste #336 Denton, TX 76205	MFDR Tracking #:	M4-05-4028-01
	DWC Claim #:	
	Injured Employee:	
Respondent Name and Box #: St Paul Fire & Marine Insurance Rep Box # : 05	Date of Injury:	
	Employer Name:	HOPE LUMBER & SUPPLY CO INC
	Insurance Carrier #:	WVK9102185 09W

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "The carrier did not pay the MAR for any of the dates of service even after we supplied the carrier with our letter from CARF."

Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)
3. EOB(s)
4. Additional Documentation

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

The Respondent did not submit a response to DWC-60.

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and/or Description	Part V Reference	Amount Due
04/19/04 04/22/04 04/23/04 04/26/04 04/27/04	F(598, 663), D	97545-WH-CA, 5 units	1 – 3	$128.00
		97546-WH-CA, 6 hrs X 5 days		$384.00
Total Due:				$512.00

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, sets out the reimbursement guidelines.

1. This dispute relates to CPT codes 97545-WH-CA (Work Hardening), and CPT Code 97546-WH-CA (Work Hardening/each additional hour), denied with reason codes "F - (598) The reimbursement for this procedure has been calculated according to the guidelines for a program that is not CARF accredited, (663) Reimbursement has been calculated according to the state fee schedule guidelines"; and reconsideration EOB for date of service 04/19/04 denied with reason code "D- (999) Duplicate bill. $617.00 of the charges are duplicates of bill #1050-H-99196-0."

2. The Respondent did not respond to the Division with documentation to support their denial "D-Duplicate bill."

3. Review of additional information provided by the Requestor indicates that the Requestor is a CARF accredited facility. The Respondent made payment at the non-CARF accredited rate. Per Rule 134.202(e)(5)(C)(i-ii) additional reimbursement is recommended as follows:
   - 04/19/04 through 04/27/04 CPT Code 97545-WH-CA: $128.00($128.00 X 5 units = $640.00 – $512.00 paid = $128.00) is recommended.
   - 04/19/04 through 04/27/04 CPT Code 97546-WH-CA: $384.00 ($64/hr X 30 hrs = $1,920.00 - $ 1,536.00 paid = $384.00) is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §133.1, §133.307, §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 additional reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $512.00 plus accrued interest, due within 30 days of receipt of this Order.

Decision:

		04/25/07
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.