



## MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

### PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (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 Suite 336 Denton, TX 76205	MDR Tracking No.: M4-05-5536-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Texas Mutual Insurance Rep Box # 54	Date of Injury:
	Employer's Name: EM Marine Inc.
	Insurance Carrier's No.: 99D0000355575

### PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor states the carrier did not pay the MAR.  
 Principle Documentation:

1. Requestor's position statement
2. TWCC-60
3. EOB's
4. HCFA's

### PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent states the accurate coding of "F" for services rendered is essential for proper reimbursement.  
 Principle Documentation: 1. TWCC-60 Response

### 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)
04/30/04	F	20550	1	\$270.36
TOTAL DUE				\$270.36

### PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

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

1. CPT Code 20550 for date of service 04/30/04 denied with "F". Per Rule 134.202(b) and CMS (Center For Medicare Services) reimbursement in the amount of \$270.36 ( $\$54.07 \times 125\% = \$67.59 \times 4 \text{ units} = \$270.36$ ) is recommended.

### PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. §413.011(a-d)  
 28 Texas Administrative Code Sec. §134.201  
 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 \$270.36.**

Ordered by:

03/16/06

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Typed Name

\_\_\_\_\_  
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.**