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 E. South, Ste 336 Denton, Texas 76205	MDR Tracking No.: M4-05-5543-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Target Corp Box 39	Date of Injury: Employer's Name: Target Corp Insurance Carrier's No.: 039CBB7K5281

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: "The carrier incorrectly paid stating that they had paid the MAR."

Principle Documentation:

1. DWC-60/Table of Disputed Service/Summary Position
2. CMS-1500's
3. EOB's

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: "The carrier has reimbursed the provider in the sum of $800.00. Attached as Exhibit 1 is the carrier's EOB. It is the carrier's position that the provider is not entitled to any additional reimbursement."

Principle Documentation:

1. DWC-60/Table of Disputed Service/Position Summary
2. EOB's.

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)
04/29/04	FEES-F DDUP-D	CPT code 97799-CP-CA ($125.00 x 8 hours)	1-3	$200.00
Total				$200.00

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

1. The Respondent denied these services as "F-The procedure code is reimbursed based on the medical fee schedule. D-The listed service/procedure cannot be billed in multiple increments on the same day or exceed the maximum number of services for the claim."

2. The Requestor submitted documentation that supports the services rendered per Rule 134.202 (e)(5)(E).

3. The Respondent reduced the amount reimbursed to the Requestor for the date of service 04/29/04, indicating that the Requestor exceeded the maximum number of services for the claim. The Requestor did not exceed the amount of services billed per Rule Per Rule 134.202 (e)(5)(E)(i). Requestor submitted proof that they are CARF accredited and due reimbursement for the CARF accredited program 100% of the MAR of $125.00 per hour per Rule 134.202 (e)(5)(A). The total amount billed of 8 hours equals $1,000.00 - $800.00 already paid by the Carrier = $200.00 in additional reimbursement 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 (e)(5)(E) and (e)(5)(E)(ii)

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 $200.00.** The Division hereby ORDERS the Respondent to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30 days receipt of this Order.

Ordered by:

	Michael Bucklin	09/13/06
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.