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 I35 East, South #336 Denton TX 76205	MDR Tracking No.: M4-05-6011-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name: TEXAS MUTUAL INSURANCE CO Representative Box #54	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position Summary states in part: "…The carrier did not pay the MAR…"

Principle Documentation: 1. DWC 60
2. Position Summary
3. CMS 1500's
4. EOB's

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position Summary: No Position Summary submitted

Principle Documentation: 1. No documentation submitted

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)
6/1/04	26, YF	97750-FC x 12 units	1	$137.20
TOTAL DUE				$137.20

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. Code 97750-FC, on date of service 6/1/04, was denied with exception codes "26 – The charge exceeds the scheduled value and or a time parameter that would appear reasonable" and "YF – Reduced or denied in accordance with the appropriate fee guideline ground rules and/or maximum allowable reimbursement (MAR)." Per 28 Texas Administrative Code Sec. §134.202 (e)(4), "…reimbursement shall be…a maximum of three hours for the discharge test…" Documentation submitted by the Requestor indicates that this is a discharge functional capacity examination. The Requestor billed for 12 units and was reimbursed for 8 units. Therefore, additional reimbursement in the amount of $137.20 is recommended for this date of service in dispute.

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
28 Texas Administrative Code Sec. §134.202 (e)(4)

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 **$137.20**. 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:

	James Schneider	4/5/07
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.