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, Suite # 336 Denton, TX 76205	MFDR Tracking #: M4-05-7931-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: Lumbermens Mutual Casualty Co. Rep Box # 42	Date of Injury: Employer Name: Johnson & Johnson Insurance Carrier #: 4210032243

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "…The carrier failed to respond to our request for reconsideration. This is a violation of Rule 133.304…"

Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "… Per IME on 04/26/02 injury not work related…"

Principle Documentation:

1. 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
05/28/04-09/03/04	NO EOB's	99213-OfficeVisit x3	1-5	$185.94
Total Due:				$185.94

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 code 99213 for date of service 05/28/04 in Denton county, there were no EOB's submitted with the dispute therefore this dispute will be reviewed according to the 2002 Medical Fee Guideline.

2. A Decision & Order dated October 6, 2000 from a Benefit Contested Case Hearing held on August 29, 2000 at the Denton Field Office revealed the claimants compensable injury sustained on April 25, 1995 extends to the cervical spine and Complex Regional Pain Syndrome was work related.

3. Per the CMS-1500's that were submitted the diagnosis codes billed were 337.9- Unspecified disorder of autonomic nervous system, and 729.5- Pain in limb. These diagnoses have been deemed compensable per the case hearing.

4. Neither party submitted EOB's for the disputed dates of service. Per Rule 133.307 (e) (2) (B), "if no EOB was received, convincing proof of carrier receipt of the provider request for an EOB shall be provided". The Requestor submitted a faxed confirmation sheet showing proof of Request For Reconsideration was sent to the carrier.

5. Per Rule 134.202 (c) (1) reimbursement in the amount of $185.94 ($49.58 x 125% x 3 dates of service) 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, §134.202
28 Texas Administrative Code Sec. §133.307

PART VII: DIVISION 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 reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of **$185.94** plus accrued interest, due within 30 days of receipt of this Order.

Order:

05/24/2007

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.