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 #:	M4-05-9526-01
	DWC Claim #:	
	Injured Employee:	
Respondent Name and Box #: American Home Assurance Co Rep Box # : 19	Date of Injury:	
	Employer Name:	ANDERSON MERCHANDISERS LP
	Insurance Carrier #:	YBUC80822

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "The carrier denied our request for reconsideration with PEC "O", and/or failed to respond for dates of service 10/05/04, 10/20/04, 10/21/04, 10/25/04, 10/26/04, 10/28/04, 10/29/04, 11/01/04, 11/02/04, 11/03/04 and 12/13/04."

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 Requestor has not submitted a Position Summary; however, the Requestor's rationale on the table of disputed services states: "We paid per state guidelines allowed additional amt 7/5/05 not in PPO plan."

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
10/05/04	F	20550	1, 2	$33.79
10/20/04 10/21/04 10/25/04 10/26/04 10/28/04 10/29/04 11/01/04 11/02/04 11/03/04	O	97545-WH-CA, 9 unit	1, 3, 4	$163.84
		97546-WH-CA, 6 hrs X 9 days		$542.72
12/13/04	O	99213	1, 3, 5	$6.20
		99080-73	1, 3, 6	$1.50
Total Due:				$748.05

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 20550 (Injection; single tendon sheath, or ligament), CPT Code 97545-WH-CA (Work Hardening), CPT Code 97546-WH-CA (Work Hardening/each additional hour), CPT Code 99213 (Office Visit) and CPT Code 99080-73 (Special Report); denied with reason codes F (Multiple surgical procedures billed on the same day will be reimbursed at 100% for the major procedure and 50% for each subsequent procedure per surgery ground rule D, page 64 04/01/96 Texas Medical Fee Guideline), and O (Reimbursement for your resubmitted invoice has been considered. No additional monies are being paid at this time. Bill has been paid according to PPO contract)"

2. Per Medicare, the multiple procedure rule applies to CPT Code 20550; the first procedure is paid at 100%; second, third and fourth procedures are paid at 50%. Per CMS-1500, services were rendered in Zip Code 76205 which is located in Denton County. The MFG MAR for CPT code 20550 in Denton County is $67.59. Additional reimbursement in the amount of $33.79 ($168.99 - $135.20 paid = $33.79) is recommended per Rule 134.202(c)(1).

3. Review of additional information provided by the Requestor indicates that the Requestor is a CARF accredited facility, and that they are not under a PPO discount plan.

4. Respondent made partial payment for the Work Hardening program. Per Rule 134.202(e)(5)(C)(i-ii) additional reimbursement is recommended as follows:
   - 10/20/04 through 11/03/04 – 97545-WH-CA ($128.00 X 9 units = $1,152 – $988.16 paid = $163.84 recommended)
   - 10/20/04 through 11/03/04 – 97546-WH-CA ($64/hr X 54 hrs = $3,456.00 - $2, 913.28 paid = $542.72. recommended)

5. The MFG MAR for CPT code 99213 is $61.98. Additional reimbursement in the amount of $6.20 ($61.98 - $55.78 paid = $6.20) is recommended per Rule 134.202(c)(1).

6. Per Rule 129.5(i) reimbursement for CPT code 99080-73 is $15.00, Respondent paid $13.50. Additional reimbursement in the amount of $1.50 is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §129.5, §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 $748.05 plus accrued interest, due within 30 days of receipt of this Order.

Decision and Order:

		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.