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

Requestors Name and Address: Edward F. Wolski, M.D./Wol+Med 2436 I-35 E. South , Suite #336 Denton, TX 76205	MDR Tracking No.:	M4-05-9692-01
	Claim No.:	
	Injured Employee's Name:	
Respondent's Name: Hartford Underwriters Insurance Rep Box # 27	Date of Injury:	
	Employer's Name:	O'Neal Oil properties
	Insurance Carrier's No.:	670C31519

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary states in part, "…The carrier failed to respond to our request for reconsideration for date of service 11/01/04. The carrier denied date of service 11/01/04 using PEC "N". I have included a copy of the guidelines for these CPT codes. Our documentation meets the requirements for these dates of services. We feel the carrier has failed to comply with Rule 133.304(c)…"

Principle Documentation: 1. DWC 60 package
2. CMS 1500's
3. EOBs

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent did not submit a position summary.

Principle Documentation: 1. N/A

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)
11/01/04	N	99215-Office Visit	1	$141.55
TOTAL DUE				$141.55

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. CPT Code 99215 for date of service 11/01/04 denied with "N-Documentation does not justify level of service. Resubmit using code for appropriate lower level of service". The Respondent did not respond to the request for reconsideration. The CPT code descriptor requirements for 99215 (office visit) requires; at least two of these three key components: comprehensive history, comprehensive examination, medical decision making of high complexity. The review of the documentation submitted by the Requestor indicated two of the three of the key components were met (comprehensive history & comprehensive exam). Therefore reimbursement in the amount of $141.55 ($113.24 x 125%) 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
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 reimbursement in the amount of **$141.55.** 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:

		09/29/06
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.