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

Type of Requestor: (x) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address: Edward Wolski, M. D. Wol+Med 2436 I 35 East, South Ste. #336 Denton, Texas 76205	MDR Tracking No.: M4-05-A997-01 Claim No.: Injured Employee's Name:
Respondent's Name: TEXAS MUTUAL INSURANCE CO, BOX 54	Date of Injury: Employer's Name: METAL SALES INC Insurance Carrier's No.: 99D0000362465

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary states in part, "The carrier denied DOS 12-27-04 upon reconsideration, citing that no EOB was attached. There was no EOB to attach with the claim; the carrier failed to respond to our initial billing. This information was included in the request for reconsideration."

Principle Documentation:

1. DWC 60 package
2. CMS 1500s
3. EOBs

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary (Table of Disputed Services) states: "Not received, reduced or denied."

Principle Documentation:

1. DWC 60 package

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)
12-27-04	No EOB	99213	1	$61.98
Total Due				$61.98

PART V: MEDICAL FEE 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, set out reimbursement guidelines. Dates of service 11-1-04 and 12-14-04 were withdrawn and will not be a part of this review.

1) Neither party submitted EOB's for this date of service. There is convincing evidence of Respondent receipt of the provider's request for EOBs in accordance with Rule 133.307(e)(2)(B). This date of service will be reviewed in accordance with Rule 134.202. Respondent did not provide a valid basis for the denial of this service, reimbursement is recommended in the amount of $61.98 per Rule 134.202(c)(1).

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 413.011(a-d), 413.031
28 Texas Administrative Code Sec. 133.307, 134.1, 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. The Division hereby **ORDERS** the Respondent to remit the amount of $61.98 plus all accrued interest due at the time of payment to the Requestor within 30 days of receipt of this Order.

Decision and Order by:

	Donna Auby, Medical Fee Dispute Officer	3-20-07
Authorized Signature	Typed Name	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.