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 IH35 East, South #336 Denton TX 76205	MDR Tracking No.:	M4-05-B119-01
	Claim No.:	
	Injured Employee's Name:	
Respondent's Name: LIBERTY MUTUAL FIRE INSURANCE Representative Box #28	Date of Injury:	
	Employer's Name:	
	Insurance Carrier's No.:	949667751

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position Summary states in part: "…The carrier incorrectly paid…"

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: "…Code 99213 was denied as global to code 90806..."

Principle Documentation:
1. DWC 60
2. Position summary

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)
9/16/04	U011	99213	1	$00.00
TOTAL DUE				$00.00

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 99213, on date of service 9/16/04, was denied with exception code "U011 – This procedure is mutually exclusive to another procedure on this bill. By clinical practice standards, this procedure should not/cannot be performed in the same treatment period." Per 28 Texas Administrative Code Sec. §134.202(b), code 99213 is considered to be mutually exclusive procedure of the code 90806. There are no circumstances in which a modifier would be appropriate. The services represented by the code combination will not be paid separately. Therefore, no reimbursement 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

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 not entitled to reimbursement.

Decision by:

Authorized Signature	Typed Name	Date
	James Schneider	3/9/07

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.