**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:<br>Edward F. Wolski, M.D./Wol+Med<br>2436 I-35 E. South, Suite 336<br>Denton, Texas 76205 | MFDR Tracking #: M4-07-3701-01<br>DWC Claim #:<br>Injured Employee: |
| Respondent Name and Box #:<br>LIBERTY MUTUAL INSURANCE CORP.<br><br>REP BOX #: 28 | Date of Injury:<br>Employer Name: United Parcel Service, Inc.<br>Insurance Carrier #: 949840274 |

## PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "The carrier did not respond to our request for reconsideration for DOS 2/20, 8/9, 8/18, 8/21 and 10/3/06. The MDR documentation includes a copy of the signature confirmation as proof the carrier received our request. There are some DOS which have neither been paid by the carrier nor been acknowledged as received. Since there has been no acknowledgement, we cannot submit the EOB's for theses claim(s). However, we are submitting proof of timely filing as well as proof of timely acceptance. Considering that we have this proof, it appears that the carrier in direct violation of Rule 133.304(a)(b)…408.021…Rule 133.1…Rule 133.304…"

Principle Documentation:

1. DWC 60 package
2. CMS 1500
3. EOB
4. Medical Records

## PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

The Respondent did not submit a response to this Request for Medical Fee Dispute Resolution.

Principle Documentation:

1. N/A

## PART IV: SUMMARY OF FINDINGS

| Date(s) of Service | Denial Code(s) | CPT Code(s) and/or Description | Part V Reference | Amount Due |
|---|---|---|---|---|
| 02/20/06 | X170, | 97545-WH-CA x 1 Unit | 1 | $128.00 |
| 02/20/06 | X170 | 97546-WH-CA x 2 Units | 2 | $128.00 |
| 08/09/06<br>08/18/06 | M359<br>M359 | 97750 X 2 Units<br>97750 X 2 Units | 3 | $71.02<br>$71.02 |
| 10/03/06 | X574 | 99213 | 4 & 6 | $61.63 |
| 10/03/06 | X574, Z651, W1, U301 | 99080-73 | 5 & 6 | $15.00 |
| **Total Due:** | | | | $474.67 |

**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 is related to CPT code 97545-WH-CA for date of service 02/20/06 that was denied with reason codes "X170—Pre-authorization was required, but not requested for this service per TWCC Rule 134.600." Per Rule 134.600(h), a CARF accredited program does not require pre-authorization of services. Requestor is a CARF accredited facility. In addition, per Rule 134.202 (5)(A)(i), the hourly reimbursement for a CARF accredited program shall be 100% of MAR. Rule 134.202(e)(5)(C)(ii) states, "Reimbursement shall be $64.00." Per Rule 134.202(5)(c)(i), the first two hours or each session shall be billed and reimbursed as one unit; therefore, reimbursement recommended in the amount of **$128.00 ($64.00 per hour (MAR) X 2 hours = $128.00)**.

2. This dispute is related to CPT code 97546-WH-CA X 2 Units for date of service 02/20/06 that was denied with reason codes "X170—Pre-authorization was required, but not requested for this service per TWCC Rule 134.600". Per Rule 134.600(h), a CARF accredited program does not require pre-authorization of services. Requestor is a CARF accredited facility. In addition, per Rule 134.202 (5)(A)(i), the hourly reimbursement for a CARF accredited program shall be 100% of MAR. Rule 134.202(e)(5)(C)(ii) states, "Reimbursement shall be $64.00." Therefore, reimbursement is recommended in the amount of **$128.00 ($64.00 per hour (MAR) X 2 hours = $128.00)**

3. This dispute is related to CPT code 97750 X 2 Units each for dates of service 08/09/06 and 08/18/06 that was denied with reason code "M359—Time expended on or the number of functional capacity evaluations has been exceeded." Per CMS-1500, the Requestor did not bill for an FCE, rather a PPE was billed. Therefore, per Rule 134.202 (b) and (c) (i), reimbursement in the amount of **$142.04**, **($28.41 X 125% = $35.51 (MAR) X 2 Units = $71.02 X 2 Days = $142.04)**.

4. This dispute is related to CPT code 99213 for date of service 10/03/06 that was denied with reason codes "X574—Non-certified provider for ADL" and "U301—This item was previously submitted and reviewed with notification of decision issued to payor/provider. (Duplicate invoice)." Rule 180.23, requires doctors to be on the ADL. OTR;s are not required to be on the ADL. Due to the invalid denial submitted by the Respondent, this CPT code will be reviewed and reimbursed MAR according to the 2002 Medical Fee Guideline. Per Rule 134.202(b) and (c)(i), reimbursement is recommended in the amount of **$61.63 ($49.30 X 125% = $61.63 (MAR)**.

5. This dispute is related to CPT code 99080-73 for date of service 10/03/06 that was denied with reason codes, "X574—Non-certified provider for ADL"; "U301—This item was previously submitted and reviewed with notification of decision issued to payor/provider."; and Z651/W1—this charge has been reimbursed according to the appropriate fee schedule or usual and customary value". The Respondent reimbursement the Requestor $00.00. Rule 180.23, requires doctors to be on the ADL. OTR;s are not required to be on the ADL. Due to the invalid denial submitted by the Respondent, this CPT code will be reviewed and reimbursed MAR according to the 2002 Medical Fee Guideline. Per Rules 134.202(e)(8) and 129.5(i), reimbursement in the amount of **$15.00** is recommended.

6. A referral was made to Legal and Compliance against the Respondent for violation of Rule 180.23.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION**

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §133.307 (effective 12/31/06)
28 Texas Administrative Code Sec. §134.1, §134.202, §129.5, §180.23, §134.600

**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 reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of **$474.67** plus accrued interest, due within 30 days of receipt of this Order.

**Decision:**

| | | |
|---|---|---|
| | | 04/05/07 |
| 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.**