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:	
Southwest Center Medical 7125 Marvin D. Love, Suite 107 Dallas, Texas 75237	MDR Tracking No.: M4-05-1737-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: J. C. Penney Corporation, Inc. C/o Flahive Ogden & Latson Rep Box # 19	Date of Injury: Employer's Name: J. C. Penney Corporation, Inc. Insurance Carrier's No.: 949317835

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Requestor's Position Summary states in part, "…Our charge for date of service 12-3-03 was not paid using TWCC 62 code F; Fee Guideline MAR reduction. We had requested for reconsideration via certified mail and according to USPS the carrier received on May 26, 2004. To date, the carrier has not responded to our reconsideration as required by TWCC within 28 days…"

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

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Respondent's Position Summary states in part, "…TWCC guidelines allow FCE's only threes time per injury. The claimant…has already had three FCE's related to this injury which occurred ___. Copies of bills and EOBs are attached for FCEs of 1/11/99, 2/8/99, and 9/21/01. We do not feel that any additional reimbursement is due…"

Principle Documentation:
1. Response to DWC-60 package
2. Copy of CMS 1500 and EOBs for FCE rendered on 1/11/99
3. Copy of CMS 1500 and EOBs for FCE rendered on 2/8/99
4. Copy of CMS 1500 and EOBs for FCE rendered on 9/21/01

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)
12/03/03	F	97750-FC (Functional Capacity Evaluation)	1 & 2	$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. This dispute relates to CPT code 97750-FC for date of service 12/03/03 and was denied as "F" (no explanation provided).

2. Rule 134.202(e)(4) states that a maximum of 3 FCE's for each injury shall be billed and reimbursed. The carrier stated that this is the fourth FCE performed on claimant. The first and second FCE's were performed on 01/11/99

and 02/08/99 by Dallas Spinal Rehab Center. The third FCE was performed on 09/21/01 by Tom Mayer, M.D.

3. Per 134.202(e)(4), reimbursement is not recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.1
28 Texas Administrative Code Sec. §134.202(e)(4)

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:

		11/13/06
Authorized Signature	Typed Name	Date of Decision

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.