MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Texas Mutual Insurance Co. Box 54 c/o Reeves & Brightwell 8911 N. Capital of Texas HW, Westech 360, Ste. 3210 Austin, TX 787859-7249	MDR Tracking No.: M4-05-3641-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Universal Medical Evaluators 2900 Weslayan #620 Houston, TX 77027	Date of Injury: Employer's Name: Alcode, Inc. Insurance Carrier's No.: 99D000355904

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
02/19/04	**02/19/04**	**97750-FC**	**$528.00**	**$105.60**

PART III: REQUESTOR'S POSITION SUMMARY

Summary Position Statement dated 03/03/05 states in part, "…TMI is entitled to a refund of the full amount requested… because: UME is a health care provider that billed and was paid for services that were performed in a manner that violated TWCC Rules (no direct personal supervision provided). In this situation, a provider is not entitled to payment in the first instance. UME and Dr. Lee have admitted to a compensation and fee-splitting arrangement that squarely meets the meaning of disclosable financial interest. Because they have not made the requisite disclosures under Rule 190.25, TMI is entitled to the requested refunds. If full refunds are not ordered on the above grounds, TMI is entitled to refund of the partial amount because: UME charged TMI a higher amount for the FCEs than it paid the doctor. Rule 134.801, prohibits this… UME overbilled for the FCEs it performed by billing more units than were required for the exam…"

PART IV: RESPONDENT'S POSITION SUMMARY

Summary Position Statement dated 03/14/05 states in part, "…Universal Medical Evaluators, Inc. (UME) makes this response to TMI's Reply Letter in Support of its Requests for Medical Dispute Resolution… TMI fails to respond to the plain fact that the doctor who performed the medical service of evaluating the patient and certified the result for the referring physician is the billing party and the only proper respondent to this medical dispute resolution proceeding… The patient was referred by a physician to Dr. Lee for a functional capacity evaluation. UME, not being a doctor, or other licensed health care provider, is not qualified to provide such an evaluation… The Workers Compensation Commission Medical Fee Guidelines do not require that FCEs be conducted under the direct personal supervision of a doctor. Subsection (e) of the amended §134.202 adopts policies relating to services, such as FCEs, which are 'specific to and necessary in the Texas Workers' Compensation system that are not commonly used or not used at all in the Medicare System.' Although §134.202(e)(4) provides that FCEs are to be billed as a 'physical performance test or measurement' CPT code, there is no stated requirement that Medicare requirements imposed upon physical therapists are adopted as a part of the MFGs for this service which is unique to workers' compensation system…TMI relates a story of an unidentified injured worker report that his FCE lasted less than two hours, but fails to point the Commission or UME to a specific set of facts. Using the methodology set forth in footnote 9, TMI estimates that an FCE should take two hours. Anyone who has even seen an FCE administered on a semi-literate injured worker who is suffering from substantial disability will acknowledge that a five hour, or longer, duration can be reasonable… UME is not required to make the financial disclosure mandated by Rule 180.24. The Rule requires submission of financial disclosures in two instances: (1) where a health care practitioner refers an injured employee to a health care provider in which he has a financial interest… and (2) a *doctor* is required to disclose financial interests as a condition of obtaining registration for the for the approved doctor list (ADL), and is required to update those disclosures when the facts reported change… UME has in none of the cases involved in this MDR made a referral. In each instance a referral was made by the Commission to a Designated Doctor, and in each instance that Designated Doctor referred the patient to Dr. Lee for an FCE.. It is not required to submit financial information under 180.24(b)(1). Just as plainly, UME is not a doctor, and of course is not on the ADL, so it did not register for the ADL and has no obligation to amend financial information previously disclosed. It is not required to do so under 180.24(b)(2)… Dr. Lee's billing process is not improper. Dr. Lee utilizes UME as, amoung other things, a billing service. In that capacity it performs the 'solely administrative function' of submitting Dr. Lee's bills. Despite TMI's implication, there is no requirement in the rules that the billing services providers perform that service and no other. In accordance with §134.801(g) UME submits Dr. Lee's bill (1) in the amount of the customary and TWCC-approved charge for an FCE, (2) submits it in the name of an licensed number of Dr. Lee; and (3) under agreement with Dr. Lee paid to him the total amount collected less the agreed cost of providing the equipment and staff support necessary for the provision of the services…"

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- CPT Code 97750-FC for date of service 02/19/04. Per Rule 134.202(e)(4) reimbursement shall be for up to a maximum of four hours for the commission ordered test and shall be billed using the physical performance test or measurement. Per Rule 134.202(b) the Respondent documented the testing time to be 5 hours and billed for 20 15-minute increments at $26.40 per increment. Although the Medical Fee Guideline allows $36.75 ($29.40 x 125%) for each 15 minutes. the Respondent rendered services outside the parameters of the Fee Guideline; therefore, reimbursement in the amount of $105.60 is recommended.
- Regarding the issue of financial disclosure, MDR finds no provision in the medical fee guideline that would restrict reimbursement due to the failure to properly disclose any potential relationship. Those issues are not under the purview of Medical Dispute Resolution.

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to a refund in the amount of $105.60. The Division hereby **ORDERS** the Respondent to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

	Marguerite Foster	04/20/05
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____________. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: ____ Date: ________________________