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 Wol-Med 7125 Marvin D. Love Frwy #107 Dallas, TX 75237	MDR Tracking No.: M4-05-9581-01 (formerly M4-04-A123-01) TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 28 Southwestern Bell Telephone LP C/o Liberty Mutual Insurance 2875 Browns Bridge Rd. Gainesville, GA 30504	Date of Injury: Employer's Name: Southwestern Bell Telephone LP Insurance Carrier's No.: 949731918

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**			
04/12/04	**04/12/04**	**CPT Code 97750-FC**	**$444.60**	**$149.96**

PART III: REQUESTOR'S POSITION SUMMARY

Carrier did not allow any payment for our bill and did not provide any explanation of why. We resubmitted in our request stating that since the carrier denied under code F, we provided that there is an allowed MAR for 2004 TWCC/Medicare MFG of $444.60. We also requested that an explanation of non-payment be provided as required by TWCC. The carrier still continues to ignore our request…

PART IV: RESPONDENT'S POSITION SUMMARY

Attached is documentation showing that the provider has already been reimbursed $1091.04 for FCE's. Instead of 16 units for the 6/25/03 initial test, the provider billed 20 units. For the 10/3/03 test another 16 units were billed. These have all been reimbursed. The guidelines and limits for FCE's from the Fee Guidelines are attached along with the EOBs showing our payments. Two additional tests were done by other providers on 8/21/03 and on 11/18/03 but these were TWCC ordered tests…

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

CPT Code 97750-FC (12 units/3 hours) for date of service 04/12/04 denied as "F". Per Rule 134.202(e)(4) the requestor is seeking reimbursement of $444.60 for a 3-hour discharge FCE for which the insurance carrier has made no payment.

While the only date of service in dispute is 04/12/04, due to the insurance carrier response a review of the first two FCE's and payments made must be taken into consideration. The first date of service of 06/25/03, the healthcare provider billed the maximum of 5 hours per the '96 MFG, MGR (E)(2) and received the correct payment amount of $500.00. The interim FCE of 10/03/03, according to the CMS 1500, submitted by the insurance carrier, shows the healthcare provider billed 16 units (15 minute increments); however, per the 2002 Medical Fee Guideline, as referenced above, the maximum allowable time for an interim test is two hours payable at $37.05 per unit for a total billable amount of $296.40. The insurance carrier paid a total of $591.04, which is an overpayment of $294.64.

The final FCE was performed on 04/12/04 for which the healthcare provider billed 3 hours/12 units for a total billable amount of $444.60. The FCE report, submitted by the healthcare provider supports services were rendered as billed; however, due to the overpayment of $294.64 the total reimbursement recommended is $149.96.

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 additional reimbursement in the amount of $149.96. The Division hereby **ORDERS** the insurance carrier 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	June 27, 2005
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: ________________________