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: AccuTrust Diagnostics Inc. P.O. Box 121586 Arlington, TX 76012	MFDR Tracking #:	M4-07-3497-01
	DWC Claim #:	
	Injured Employee:	
Respondent Name and Box #: ACE American Insurance Co Rep Box #: 15	Date of Injury:	
	Employer Name:	TRINITY INDUSTRIES INC
	Insurance Carrier #:	4650196151

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

The Requestor has not submitted a Position Summary; however, the Requestor's rationale on the table of disputed services states, "Billed according to Texas Fee Schedule."

Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)
3. EOB(s)

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

The Respondent did not submit a response to DWC-60.

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and/or Description	Part V Reference	Amount Due
04/03/06	147, W1 W4 (112-003, 663, 900)	97750-FC	1, 2	$17.30
Total Due:				$17.30

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 relates to CPT code 97750-FC (Physical performance test) denied on original EOB with reason code "147 – Provider contracted/negotiated rate expired or not on file; W1 – Workers compensation State Fee Schedule Adjustment" and recon EOB denial reason code "W4 – No additional reimbursement allowed after review of appeal/reconsideration; 112-003 – The primary provider is a non-contracted provider; 663 – Reimbursement has been calculated according to the state fee schedule guidelines; 900 – Based on further review, no additional allowance is warranted. "

2. Per the CMS-1500, services were rendered in Zip Code 78704 which is located in Travis County. The MFG MAR for CPT code 97750-FC in Travis County is $38.11. Per Rule 134.202(c)(1) additional reimbursement in the amount of $17.30 ($38.11 x 10 units = $381.10 - $363.80 paid = $17.30) is recommended.

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), §134.1, §134.202

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 $17.30 plus accrued interest, due within 30 days of receipt of this Order.

Decision and Order:

		05/02/07
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.