Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Diagnostic Imaging Institute, Inc. P.O. Box 743125 Dallas, TX 75374	MFDR Tracking #: M4-07-5454-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: Travelers Indemnity Co. Box #05	Date of Injury: Employer Name: EW Scripps Co. Insurance Carrier #: 478CBABG8547

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary taken from the Table of Disputed Services: "FCE requested by Designated dr."

Principle Documentation:

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

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary:

"DB this is the 2nd FCE for the life of the claim provider is only allowed 8 units for 2nd FCE…"

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
6-28-06	W1, W4	97750FC (12 units)	1-6	$142.04
Total Due:				$142.04

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. These services were denied by the Respondent with reason code "W1-Workers Compensation State F/S Adj. FCEs are allowed 3 times per injured worker. The 2nd FCE has a maximum of two hours (8) units; and W4-No additional reimbursement allowed after review of appeal/reconsideration. After carefully reviewing the resubmitted invoice. Additional reimbursement is not justified."

2. According to Rule 130.6(m), "For testing other than that listed in subsection (l) of this section, the designated doctor may perform additional testing or refer the employee to other health care providers when deemed necessary to assess an impairment rating. Any additional testing required by the AMA Guides for the assignment of an impairment rating is not subject to preauthorization requirements in accordance with Labor Code §413.014

(relating to Preauthorization) and additional testing must be completed within seven working days of the designated doctor's physical examination of the employee."

3. Rule 134.202(e)(4), states in part "Functional Capacity Evaluation (FCE). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the commission shall not count toward the three FCEs allowed for each compensable injury…Reimbursement shall be for up to a maximum of four hours for the initial test or for a commission ordered test…"

4. On this date, the Requestor billed for 12 units of CPT code 97750-FC and was paid for 8 units. The disputed FCE was Division ordered; therefore, the insurance carrier incorrectly paid per Rule 134.202(e)(4).

5. Per Commissioner's Bulletin #B-0006-06, "The CY 2005 conversion factor of $37.8975 is to be used effective immediately when calculating MAR for services provided on or after January 1, 2006."

6. Per CMS-1500, the zip code 78410 is located in Bexar County. The MFG MAR for CPT code 97750-FC in Nueces County is $35.63 or less per Rule 134.202(d)(2). Per the Table of Disputed services, the Requestor is seeking medical dispute resolution for $35.51 per unit of FCE. The reimbursement of $35.51 X12 = $426.12, minus amount paid of $284.08 = $142.04, this amount is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.1, §134.202, 130.6

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 additional reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $142.04 plus accrued interest, due within 30 days of receipt of this Order.

ORDER / DECISION:

	Elizabeth Pickle, RHIA	June 27, 2007
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.