



MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity and Fee Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address: Summit Rehabilitation Centers 2420 E Randol Mill Rd. Arlington TX 76011	MDR Tracking No.: M5-06-1238-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Travelers Indemnity Company, Box 05	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 package. Position paper states, "Provider sent a request for reconsideration. Proof that carrier received request is also included. Carrier chose not to respond within the 28 day time frame rule."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included DWC 60 response. Position paper states, "Unit Manager has deemed that these should have been paid."

PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
	Requestor withdrew medical necessity services.		

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

In a Revised Table of Disputed Services dated 4-11-06 the Requestor withdrew all dates of service except CPT code 97750-FC on 6-27-05. Therefore, the file contains unresolved medical fee issues only. The Division shall proceed to resolve the medical fee dispute in accordance with Rule 133.307.

4 units of CPT code 97750-FC on 6-27-05 were denied by the carrier as "W1-FCE's are allowed three times per injured worker. The 2nd FCE has a maximum of two hours (8 units)." Rule 134-202 (e)(4) states: "A maximum of three FCE's for each compensable injury shall be billed and reimbursed. FCE's shall be billed using the "Physical performance test or measurement... CPT code with modifier "FC." FCE's shall be reimbursed in accordance with subsection (c)(1). Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required." Information was submitted which reveals that this is a discharge FCE test. The requester is billing for 12 units (three hours) of this CPT code, which is according to the Rule. The requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F). The carrier has reimbursed \$309.20. Additional reimbursement of \$154.60 is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.307, 134-202 (e)(4).

PART VII: DIVISION DECISION

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 in the amount of \$154.60. 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 30 days of receipt of this Order.

Findings and Decision and Order by:

Donna Auby

5-3-06

Authorized Signature

Typed Name

Date of Order

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.