



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

GULF COAST MEDICAL EVALUATIONS

Respondent Name

METROPOLITAN TRANSIT AUTHORITY

MFDR Tracking Number

M4-11-2708-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

APRIL 11, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It has come to my attention that your company is denying the above mentioned date's of service because required documentation is needed to support or meet the criteria for this testing. I have researched the fee guidelines and all of the criteria needed have been met. I have again attached the original documentation submitted upon initial billing. This is an FCE report and all of the results are documented throughout in this report."

Amount in Dispute: \$816.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts that the charges were appropriately denied based upon the denial codes and explanations identified in its EOBs. The carrier incorporates those denial codes and explanations into this response."

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 29, 2010	CPT Code 97750-FC (16 units) Functional Capacity Evaluation (FCE)	\$816.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.204 and §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
- The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 150-Payment adjusted because the payer deems the information submitted does not support his level of service.

- 150-Documentation submitted does not support the level of service required for a FCE. Per DWC rule 134.204(g): FCEs shall also include the following elements: (1) A physical examination and neurological evaluation, which include the following: (A) appearance (observation and palpation); (B) flexibility of the extremity joint or spinal region (usually observational); (C) posture and deformities.
- 193-Original payment decision is being maintained. This claim was processed properly the first time.

Issues

1. Does the documentation support billing CPT code 97750-FC?
2. Is the requestor entitled to reimbursement for the FCE rendered on November 29, 2010?

Findings

The respondent denied reimbursement for the disputed FCE based upon reason code "150."

28 Texas Administrative Code §134.204 (g) states "The following applies to Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the Division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title. 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. FCEs shall include the following elements:

- (1) A physical examination and neurological evaluation, which include the following:
 - (A) appearance (observational and palpation);
 - (B) flexibility of the extremity joint or spinal region (usually observational);
 - (C) posture and deformities;
 - (D) vascular integrity;
 - (E) neurological tests to detect sensory deficit;
 - (F) myotomal strength to detect gross motor deficit; and
 - (G) reflexes to detect neurological reflex symmetry.
- (2) A physical capacity evaluation of the injured area, which includes the following:
 - (A) range of motion (quantitative measurements using appropriate devices) of the injured joint or region; and
 - (B) strength/endurance (quantitative measures using accurate devices) with comparison to contralateral side or normative database. This testing may include isometric, isokinetic, or isoinertial devices in one or more planes.
- (3) Functional abilities tests, which include the following:
 - (A) activities of daily living (standardized tests of generic functional tasks such as pushing, pulling, kneeling, squatting, carrying, and climbing);
 - (B) hand function tests that measure fine and gross motor coordination, grip strength, pinch strength, and manipulation tests using measuring devices;
 - (C) submaximal cardiovascular endurance tests which measure aerobic capacity using stationary bicycle or treadmill; and
 - (D) static positional tolerance (observational determination of tolerance for sitting or standing)."

CPT code 97750 is defined as "Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes." CPT code 97750 requires direct one-on-one patient contact.

A review of the submitted FCE report finds that the requestor did not document a physical examination and neurological evaluation, key elements required by 28 Texas Administrative Code §134.204 (g)(1). Therefore, the Division concludes that the requestor has not supported billing for the FCE. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

07/10/2014

Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

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

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