



# 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](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

MARCUS P. HAYES, DC

**Respondent Name**

FIREMANS FUND INSURANCE CO

**MFDR Tracking Number**

M4-14-2878-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

MAY 16, 2014

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "This particular claim was completed and submitted properly with the appropriate supporting documentation. When the carrier asserted that the claim was lacking information, the appropriate documentation was again submitted. The carrier has now received all relevant information pertaining to this claim twice and has inappropriately denied the claim twice...This was the claimant's second or interim FCE."

**Amount in Dispute:** \$399.52

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Please see the EOBs...Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

**Response Submitted By:** Flahive, Ogden & Latson

#### SUMMARY OF FINDINGS

| Dates of Service  | Disputed Services   | Amount In Dispute | Amount Due |
|-------------------|---|-------------------|------------|
| February 20, 2014 | CPT Code 97750-FC (8 units)<br>Functional Capacity Evaluation (FCE) | \$399.52          | \$399.52   |

#### 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:
  - 16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
  - X358-Documentation to substantiate this charge was not submitted or is insufficient to accurately review this charge.
  - 18-Duplicate claim/service.

- U301-This item was previously submitted and reviewed with notification or decision issued to payor, provider (duplicate invoice).
- W3-Request for reconsideration.
- ZD86-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

### **Issues**

1. Does the documentation support the level of service billed?
2. Is the requestor entitled to reimbursement for the FCE rendered on February 20, 2014?

### **Findings**

1. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.204.

On the disputed date of service, the requestor billed CPT code 97750-FC.

The American Medical Association (AMA) Current Procedural Terminology (CPT) defines CPT code 97750 as "Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes."

The requestor appended modifier "FC" to code 97750. 28 Texas Administrative Code §134.204(n)(3) states "The following Division Modifiers shall be used by HCPs billing professional medical services for correct coding, reporting, billing, and reimbursement of the procedure codes. (3) FC, Functional Capacity-This modifier shall be added to CPT Code 97750 when a functional capacity evaluation is performed".

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)."

The requestor states in the position summary that the disputed FCE was the second or interim one. A review of the submitted medical bill indicates that the requestor billed for eight units, which equals two hours; therefore, the requestor did not exceed the two hour limit set in 28 Texas Administrative Code §134.204(g).

The requestor submitted a copy of the FCE report that indicates it started at 9:00am and ended at 11:00am, totaling two hours of testing. As a result, reimbursement is recommended.

- 2. Per 28 Texas Administrative Code §134.204(g) to determine the reimbursement for FCEs the Division refers to 28 Texas Administrative Code §134.203(c)(1)(2).

Per 28 Texas Administrative Code §134.203(c)(1)(2), the following formula is used to calculate the Maximum Allowable Reimbursement (MAR): (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = MAR.

The 2014 DWC conversion factor for this service is 55.75.

The Medicare Conversion Factor is 35.8228.

Review of Box 32 on the CMS-1500 finds that the services were rendered in zip code 77070 which is located in Houston, Texas; therefore, the Medicare locality is "Houston, Texas."

The Medicare participating amount for CPT code 97750 is \$33.90.

Using the above formula, the MAR is \$52.76 per unit. The requestor billed for 8 units; therefore, \$52.76 X 8 = \$422.08. The respondent paid \$0.00. The difference between MAR and amount paid is \$422.08. The requestor is seeking \$399.52; this amount is recommended for reimbursement.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$399.52.

**ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$399.52 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

04/30/2015  
Date

**YOUR RIGHT TO APPEAL**

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 Texas Register 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request 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 §141.1(d).

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