



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

MICHAEL N. THOMPSON, DC

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-15-1464-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

JANUARY 16, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is my POSITION that the purpose of the FCE request was to provide the designated with this claimant's functional work capabilities which were provided and utilized in his report to answer the RTW Question portion of the DDE. The FCE is billed in units of 15 minutes for one unit. Had the Test been provided as TMI suggests, this portion would have only required 1 Unit at \$50.50. Nowhere in the rules does it allow the carrier to deny payment for all 16 units performed when only 1 Unit of what they feel should have been submitted, and all 16 units were denied with an explanation that pertained to only one unit (15 minute process) of cardiovascular testing (which was performed properly)."

Amount in Dispute: \$808.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed an incomplete FCE for services provided on the date above. The cardiovascular portion of the evaluation does not show use of a stationary bike or treadmill consistent with Rule 134.204(g)(3)(C). The requestor argues the use of these devices was contraindicated '...due to hypertension'...Texas Mutual denied payment consistent with Rule 134.201."

Response Submitted By: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 2, 2014	CPT Code 97750-FC (16 units) Functional Capacity Evaluation (FCE)	\$808.00	\$808.00

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:
 - A07-Documentation does not meet the level of service required for FCE per Rule 134.204(G).

- CAC-W3, 350-In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- CAC-150-Payer deems the information submitted does not support this level of service.
- CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 724-No additional payment after a reconsideration of services.

Issues

1. Does the documentation support the level of service billed?
2. Is the requestor entitled to reimbursement for the RCE rendered on July 2, 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 requested by the Designated Doctor. A review of the submitted medical bill indicates that the requestor billed for sixteen units, which equals four hours; therefore, the requestor did not exceed the four hour limit set in 28 Texas Administrative Code §134.204(g) for Division ordered FCEs.

The respondent denied reimbursement for the FCE because the requestor did not use a stationary bike or treadmill for the cardiovascular endurance test per 28 Texas Administrative Code 134.204(g)(3)(C). The respondent noted in the position summary that “Certainly, there are instances when the treadmill or stationary bike are not appropriate to use, e.g. below the knee amputation, hypertensive crisis, and etc. In this case the

requestor asserts the exception is hypertension yet there is no documentation of the claimant's blood pressure anywhere in the report."

The requestor contends that the cardiovascular endurance test was conducted on a flat walking surface instead of a stationary bike or treadmill due to claimant's hypertension.

A review of the report indicates that claimant's heart rate and pain increased during the cardiovascular testing. The respondent noted that an exception would be hypertension, which is the condition the requestor used to support use of the flat walking surface for testing; therefore, reimbursement is due.

- 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 76120 which is located in Fort Worth, Texas; therefore, the Medicare locality is "Fort Worth, Texas."

The Medicare participating amount for CPT code 97750 is \$33.28.

Using the above formula, the MAR is \$51.79 per unit. The requestor billed for 16 units; therefore, \$51.79 X 16 = \$828.64. The respondent paid \$0.00. The difference between MAR and amount paid is \$828.64. The requestor is seeking \$808.00; this amount is recommended for additional 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 \$808.00.

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 \$808.00 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

04/24/2015
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.