



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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

RALPH T. MUILENBURG, DC

Respondent Name

METROPOLITAN TRANSIT AUTHORITY

MFDR Tracking Number

M4-15-3753-01

Carrier's Austin Representative

Box Number 29

MFDR Date Received

JULY 16, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I HAVE CORRECTED THE CLAIM TO RECONSIDER 9 UNITS INSTEAD OF THE 16. PLEASE REIMBURSE THE CLAIM FOR PAYMENT."

Amount in Dispute: \$592.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "There has been no documentation submitted that supports submaximal cardiovascular endurance tests which measure aerobic capacity using stationary bicycle or treadmill."

Response Submitted by: Starr Comprehensive Solutions, Inc.

Respondent's Supplemental Position Summary: "The Carrier will stand on the denial of the charge made the basis of this medical fee dispute."

Response Submitted by: Pappas & Suchma, PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 19, 2014	CPT Code 97750-FC (9 Units) Functional Capacity Evaluation	\$592.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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:

- 150-Payment adjusted because the payer deems the information submitted does not support this level of service.
- 151-Payment adjusted because the payer deems the information submitted does not support this many service.
- 151-Documentation does not support number of units billed for CPT code 97750-FC. Documentation supports 137 minutes, 9 units.
- 150-Documentation submitted does not support the level of services required for an FCE. Per DWC rule 134.204(g).
- W3-Additional reimbursement made on reconsideration.
- 193-Original payment decision is being maintained. This claim was processed properly the first time.
- W3/193-Per rule 134.804, W3 is to be used when a payment is made following a request for reconsideration. The service adjustment amount.

Issues

Does the documentation support the level of service billed?

Findings

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 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).

A review of the report finds a key element for FCEs missing, specifically the maximal cardiovascular endurance test required per 28 Texas Administrative Code §134.204(g)(3)(C); therefore, the respondent’s denial is supported.

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	08/14/2015 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, 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 MFDR 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.