TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Physical Therapy Consultants

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-16-1062-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
December 21, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: Submitted documentation did not include a position statement from the requestor. Accordingly, this decision is based on the information available at the time of review.

Amount in Dispute: $662.72

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor's documentation does not include functional abilities testing, specifically cardiovascular endurance tests which measure aerobic capacity using a stationary bicycle or treadmill. This is required by Rule 134.204(g)(3)(C) … Nowhere in the cited Rule is an exception given for not performing the cardiovascular endurance testing using a stationary bicycle or treadmill…

No payment is due for an incomplete test."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 2, 2015	Functional Capacity Evaluation	$662.72	$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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - A07 – Documentation does not meet the level of service required for FCE per Rule 134.204(g)(3)(C).
   - CAC-150 – Payer deems the information submitted does not support this level of service.

Issues

Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

The dispute involves reimbursement for a Functional Capacity Examination (FCE) on date of service March 2, 2015. The insurance carrier denied disputed services with claim adjustment reason codes A07 – "DOCUMENTATION DOES NOT MEET THE LEVEL OF SERVICE REQUIRED FOR FCE PER RULE 134.204(G)3(C)," and CAC-150 – "PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THE LEVEL OF SERVICE."

28 Texas Administrative Code §134.204(g) defines the elements required to be documented for FCEs. Review of the submitted information does not support that all required elements were documented. The insurance carrier's denial reason is supported. Additional reimbursement cannot be 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

	Laurie Garnes	January 11, 2016
Signature	Medical Fee Dispute Resolution Officer	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.