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
Iron Range Rehab Center

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-16-1414-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
January 26, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Services were performed and the claim was submitted and initially denied for no prior authorization, then denied for no FC modifier, then as a duplicate, and now for a piece of information missing in the documentation submitted. We are now being told that this claim will not be reconsidered any further without this formal appeal."

Amount in Dispute: $1,152.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Second, the same Rule at (g)(3)(C) indicates cardiovascular endurance tests are to be performed with a stationary bicycle or treadmill. The requestor's documentation reflects neither. No payment is due."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 25, 2015	97750	$1,152.00	$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

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 medical fee guideline for workers' compensation specific services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing

- 732 – Accurate coding is essential for reimbursement. Modifier billed incorrectly or missing. Services are not reimbursable as billed
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
- 150 – Payer deems the information submitted does not support this level of service
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- 739 – Documentation submitted indicated and FCE was performed. Utilize the appropriate modifier
- 18 – exact duplicate claim/service

Issues

1. Does the documentation support the level of service billed?

Findings

1. The requestor is a health care provider that rendered disputed services in the state of Minnesota to an injured employee with an existing Texas Workers' Compensation claim. The health care provider was dissatisfied with the insurance carrier's final action. The health care provider requested reconsideration from the insurance carrier and was denied payment after reconsideration. The health care provider has requested medical fee dispute resolution under 28 Texas Administrative Code §133.307. Because the requestor has sought the administrative remedy outlined in 28 Texas Administrative Code §133.307 for resolution of the matter of the request for additional payment, the Division concludes that it has jurisdiction to decide the issues in this dispute pursuant to the Texas Workers' Compensation Act and applicable rules.
2. This dispute related to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.204. On the disputed date of service, the requestor submitted a corrected claim with CPT code 97750 –GP, -FC. 28 Texas Administrative Code §134.204(g)(1) and (2) states in pertinent part,

> 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. 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 submitted documentation finds that the requestor did not include a required element of the FCE, specifically, the submaximal cardiovascular endurance tests which measure aerobic capacity using stationary bicycle or treadmill; therefore, the respondent's denial is supported per 28 Texas Administrative Code §134.204(g)(3)(C). 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

		February , 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.