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
DALLAS MEDICAL MULTICARE

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-17-3270-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JULY 10, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The insurance carrier is denying payment for our claims stating that the medical report lacks information, these denials are incorrect. Medical reports (also included in this MFDR for review) have been provided to the insurance carrier in multiple occasions and we continue to receive the same denial with no congruent details as to the supporting reasoning for continuous claim denials."

Amount in Dispute: $3,389.04

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Documentation does not meet the requirements for FCE as required in the TX Medical Fee Guidelines Sec. 134.204(g)."

Response Submitted By: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 7, 2016 March 6, 2017 April 20, 2017	CPT Code 97750-FC	$3,389.04	$0.00

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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.225, effective July 7, 2016, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - P300-The amount paid reflects a fee schedule reduction.

- 18-Exactduplicate claim/service.

Issues

1. What is the applicable fee guideline?
2. Is the respondent's denial of payment supported?

Findings

1. The applicable fee guideline for functional capacity evaluations (FCEs) is 28 Texas Administrative Code §134.225.
2. According to the submitted explanation of benefits the respondent denied reimbursement for the FCEs based upon "16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication."

   28 Texas Administrative Code §134.225 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)."

   CPT code 97750 is defined as "Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes." CPT code 97750 requires direct one-on-one patient contact.

A review of the submitted Functional Capacity Evaluation reports finds the requestor did not document all the elements required for FCEs, specifically, "submaximal cardiovascular endurance tests which measure aerobic capacity using stationary bicycle or treadmill". The division finds the respondent's denial is supported and reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is not 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

		8/17/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

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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.