



**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**

MANUEL SANCHEZ, MD

**Respondent Name**

TEXAS MUTUAL INSURANCE CO

**MFDR Tracking Number**

M4-20-2677-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

JULY 13, 2020

**REQUESTOR'S POSITION SUMMARY**

"The FCE report clearly states that the patient was asked to attempt the treadmill test but refused due to complaints of severe pain...To deny payment for the entire eight units because the patient refused to perform the Treadmill Test, which is only one unit out of eight, is inappropriate."

**Amount in Dispute:** \$420.00

**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)."

**Response Submitted by:** Texas Mutual Insurance Co

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 17, 2019	CPT Code 97750-FC( X8) Functional Capacity Evaluation (FCE)	\$420.00	\$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 (DWC).

**Background**

1. 28 Texas Administrative Code (TAC) §133.307, effective May 31, 2012 sets out the procedures for resolving a medical fee dispute.
2. 28 TAC §134.203, effective March 1, 2008, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system.
3. 28 TAC §134.225, effective July 7, 2016, sets the reimbursement guidelines for functional capacity

evaluations.

4. 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 134.225.
  - 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.
  - DC4-No additional reimbursement allowed after reconsideration.
  - CAC-18-Exact duplicate claim/service.
  - DC7-Duplicate appeal. Network contract applied by Workwell.
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### **Issues**

Is the requestor entitled to additional reimbursement for CPT code 97750-FC-GP (X8) rendered on December 17, 2019?

### **Findings**

1. The requestor is seeking medical fee dispute resolution in the amount of \$420.00 for CPT code 97750-FC-GP (X8) rendered on December 17, 2019.
2. According to the explanation of benefits, the carrier denied reimbursement based upon "A07," and "CAC-150" described above.
3. The applicable fee guideline for FCEs is found at 28 TAC §134.225.
4. 28 TAC §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).

5. A review of the submitted FCE 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 DWC finds the respondent's denial is supported and reimbursement is not recommended.

### **Conclusion**

For the reasons stated above, the DWC finds that the requestor has not established that 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 DWC has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

### **Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

08/6/2020  
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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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 DWC. **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.**