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

GENERAL INFORMATION

Requestor Name
DALLAS TESTING, INC

Respondent Name
TRUMBULL INSURANCE COMPANY

MFDR Tracking Number
M4-20-2895-02

Carrier's Austin Representative
Box Number 47

MFDR Date Received
August 11, 2020

Response Submitted By
Burns Anderson Jury & Brenner, L.L.P.

REQUESTOR'S POSITION SUMMARY

"The above date of service was not paid in full due to the following reasons(s): 'The charge for this procedure exceeds the fee schedule allowance.' This is incorrect. The fee schedule allows for **$472.64** to be charged for a FUNCTIONAL CAPACITY EVALUATION that last **2 hours**."

RESPONDENT'S POSITION SUMMARY

"Dallas Testing administered six functional/physical capacity evaluations for a lumbar sprain on: January 10, 2019, February 21, 2019, April 24, 2019, June 27, 2019, August 22, 2019, and December 12, 2019. Except for the December disputed date of service, Trumbull has issued payment for these evaluations. Although Dallas Testing listed the evaluations performed in January, February, and April of 2019 to be a physical performance evaluation (PPE), the medical evidence supports the billing of an FCE exam. While the Division rules only require Trumbull to pay for three functional capacity evaluations, it gratuitously payed for two additional evaluations.

Dallas Testing has attempted to circumvent the FCE limitations outlined above by billing modifier 97750-GP. Dallas Testing has met all the components of the FCE examination; and therefore, must adhere to the billing requirements under Division rule 134.204(g). Dallas Testing request for payment in excess of the three FCE requirement is improper and should be dismissed."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 12, 2019	CPT Code 97750-FC (X8) Functional Capacity Evaluation (FCE)	$472.64	$0.00

AMENDED FINDINGS AND DECISION

By Official Order Number 2807 dated October 17, 2013, the undersigned has been delegated authority by the Commissioner to amend fee dispute decisions.

This amended findings and decision supersedes all previous decisions rendered in this medical payment dispute involving the above requestor and respondent.

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 (TAC), 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 FCEs.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment code:
   - P12-Workers compensation jurisdictional fee schedule adjustment.
   - 296-Service exceeds maximum reimbursement guidelines.
   - W3-Additional payment made on appeal/reconsideration.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 1014-The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

Issues

Is the requestor entitled to reimbursement for CPT Code 97750-FC (X8) rendered on December 12, 2019?

Findings

1. The requestor seeks medical fee dispute resolution for CPT Code 97750-FC (X8) rendered on December 12, 2019 in the amount of $472.64.

   According to the explanation of benefits, the carrier denied for the disputed FCE based upon P12 and 296. (code description above)

   - The applicable fee guideline for FCEs is found at 28 TAC §134.225

     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.
   - Review of the submitted documentation finds that the requestor billed the following:

DOS	CPT Code	Modifier
1/10/2019	97750	GP
2/21/2019	97750	GP
4/24/2019	97750	GP
6/27/2019	97750	FC
8/22/2019	97750	FC
10/31/2019	97750	FC
12/12/2019	97750	FC

   - The DWC finds that the insurance carrier's denial reason is supported. The requestor submitted insufficient documentation to support the reimbursement of the 4th FCE, CPT Code 97750-FC rendered on December 12, 2019. As a result, reimbursement cannot be 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 Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		December 11, 2020
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, effective May 31, 2012, *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 MDR 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.