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
GULF COAST FUNCTIONAL TESTING

Respondent Name
LIBERTY MUTUAL INSURANCE CO

MFDR Tracking Number
M4-21-0841-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
JANUARY 25, 2020

REQUESTOR'S POSITION SUMMARY

"We feel that our facility should be paid according to the workers compensation fee schedule guidelines."

Amount in Dispute: $600.00

RESPONDENT'S POSITION SUMMARY

"The bill for DOS 08/18/2020 has been reviewed and denial stands as this is the 4th FCE billed for injury."

Response Submitted By: Liberty Mutual Insurance Co

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 18, 2020	CPT Code 97750-FC-GP (X8) Functional Capacity Evaluation (FCE)	$600.00	$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 §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.

Issues

Is the requestor entitled to reimbursement for CPT code 97750-FC-GP (X8) rendered on August 18, 2020?

Findings

1. The requestor is seeking medical fee dispute resolution for CPT code 97750-FC-GP (X8) rendered on August 18, 2020 in the amount of $600.00.
2. According to the explanation of benefits, the carrier paid $0.00 for the disputed FCE based upon the test exceeded the fee guideline.
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. "

The DWC finds claimant had an FCE on May 29, 2019, February 27, 2020, June 2, 2020 and August 18, 2020. The disputed FCE is the fourth FCE. The requestor did not support that the disputed FCE was a division ordered test and met exception to number of tests allowed in the fee guideline; therefore, 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	03/11/2021 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.