TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Peak Integrated Healthcare

Respondent Name
Liberty Mutual Fire Insurance Co.

MFDR Tracking Number
M4-22-1402-01

Carrier's Austin Representative
Box Number 1

DWC Date Received
March 10, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 1, 2021	CPT Code 97750-FC (X7) Functional Capacity Evaluation (FCE)	$421.89	$0.00
	Total	$421.89	$0.00

Requestor's Position

"The patient has only had 2 other FCE's for this DOI."

Amount in Dispute: $421.89

Respondent's Position

"The bill for DOS 12/1/2021 has been reviewed and denial stands as this is the 4th FCE billed for injury."

Response Submitted by: Liberty Mutual Insurance Company

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.225 sets the reimbursement guidelines for FCEs.

3. 28 TAC §134.203 sets out the fee guidelines for professional services.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- P12-Workers' compensation jurisdictional fee guideline.
- 296-Service exceeds maximum reimbursement guidelines.

Issues

1. Is Liberty Mutual Insurance Company's denial based on exceeding the fee guideline supported?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $421.89 for CPT code 97750-FC (X7) rendered on December 1, 2021.

   According to the explanation of benefits, the carrier denied payment for the disputed FCE based upon "296-Service exceeds maximum reimbursement guidelines." In support of the denial the respondent submitted copies of Explanation of benefits that support the claimant underwent FCEs on October 24, 2019, March 11, 2021, August 18, 2021 and December 1, 2021.

2. The 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. "

The DWC finds the respondent supported denial of payment because disputed FCE was the 4th one for the compensable injury.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to reimbursement for the disputed services.

Authorized Signature

		03/22/2022
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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.