



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

North Texas Pain Recovery Center

Respondent Name

Texas Mutual Insurance Co

MFDR Tracking Number

M4-23-0343-01

Carrier's Austin Representative

Box Number 54

DWC Date Received

October 11, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 2, 2022	97750 FC	\$494.23	\$0.00
Total		\$494.23	\$0.00

Requestor's Position

"The provider contends that the documentation requirements are met and that carrier is in violation of Rule 133.3 (a) in failing to identify the what elements the documentation are insufficient."

Amount in Dispute: \$494.23

Respondent's Position

"In the submitted documentation from the health care provider, page 3/5 states that a Tied UP and go TUG) test was performed for the cardio portion which is not consistent with rule 134.225 section 3C. Our position is that no payment is due."

Response submitted by: Texas Mutual Insurance

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 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.225 sets out the documentation requirements of functional capacity evaluations.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- A07 – Documentation does not meet the level of service required for FCE per Rule 134.225.
- 150 – Payer deems the information submitted does not support this level of service
- 18 – Exact duplicate claim/service
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

1. Is the insurance carrier's denial supported?

Findings

1. The requestor is seeking reimbursement of a functional capacity evaluation. The insurance carrier denied the charge stating the documentation requirements of the evaluation was not met.

DWC Rule 134.225 states in pertinent part, 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).

Review of the submitted documentation under "Cardiovascular" found insufficient evidence to support the use of a stationary bicycle or treadmill to measure aerobic capacity. The insurance carrier's denial is supported no additional payment is recommended.

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 additional reimbursement is due.

Order

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

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

November 4, 2022

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 electrónico CompConnection@tdi.texas.gov.