



## Medical Fee Dispute Resolution Findings and Decision General Information

**Requestor Name**

Monarch Rehabilitation & Sport

**Respondent Name**

Texas Mutual Insurance

**MFDR Tracking Number**

M4-25-1643-01

**Carrier's Austin Representative**

Box Number 54

**DWC Date Received**

March 19, 2025

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 15, 2024	97750-FC x 16	\$1,600.00	\$0.00

### Requestor's Position

"Bill denied for the first time on 11/19/24 for reason code A07 - documentation does not meet the level of service required for FCE per rule 134.225. A reconsideration was submitted with documentation attached on 02/13/25 and the bill denied again on 03/07/25 for the same reason. This denial reason does not effectively make any sense as all information/ documentation was submitted and received accordingly. "

**Amount in Dispute:** \$1,600.00

### Respondent's Position

"MONARCH PAIN CARE CENTER billed for a functional capacity evaluation (FCE). The documentation does not support the cardiovascular endurance tests which measure aerobic capacity using a stationary bicycle or treadmill per Rule 134.225(3)(C). 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 Texas Administrative Code \(TAC\) §133.307](#) sets out the procedures for resolving medical fee disputes.
2. [28 TAC §134.225](#) sets the reimbursement guidelines for FCEs.

## **Adjustment Reasons**

The insurance carrier denied the payment for the disputed service 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.
- 891 - No additional payment after reconsideration.

## **Issues**

1. Is the Insurance Carrier's reimbursement reduction reason(s) supported?
2. Is the Requester entitled to additional reimbursement for CPT code 97750-FC?

## **Findings**

1. The insurance carrier denied payment for a functional capacity evaluation conducted on October 15, 2024, which was billed under CPT Code 97750-FC. The denial reason code provided was "A07 - Documentation does not meet the level of service required for FCE per rule 134.225."

28 TAC §134.225 (3) states, "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)."

A review of the submitted documentation finds that the requester did not provide sufficient documentation to support cardiovascular endurance tests using stationary bicycle or treadmill were performed. DWC finds that the Insurance Carrier's reimbursement reduction reason is supported.

2. The requester is seeking reimbursement in the amount of \$1,600.00 for 16 units of CPT code 97750-FC rendered on October 15, 2024.

The applicable fee guideline for FCEs is found at 28 TAC §134.225, which 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) 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 division finds that the insurance carrier's denial reason is supported, as a result reimbursement cannot be recommended for CPT code 97750-FC conducted on October 15, 2024.

### **Conclusion**

The outcome of this medical fee dispute is based on the evidence presented by the requester 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 not due.

### **Order**

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to \$0.00 reimbursement for the disputed service.

### **Authorized Signature**

\_\_\_\_\_  
Signature

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

April 15, 2025  
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](http://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](mailto: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](mailto:CompConnection@tdi.texas.gov).