



## Medical Fee Dispute Resolution Findings and Decision General Information

**Requestor Name**

Austin Chiropractic Associates

**Respondent Name**

Hartford Insurance Co of Illinois

**MFDR Tracking Number**

M4-25-1568-01

**Carrier's Austin Representative**

Box Number 47

**DWC Date Received**

March 12, 2025

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 25, 2024	97750-FC x 16	\$299.50	\$0.00

### Requestor's Position

"The above-mentioned insurance company is refusing to pay the accurate amount due. The service code in dispute is 97750-FC (functional capacity evaluation testing) billed in the amount of \$1360.00 (16 units) We received a partial \$835.70 payment. The correct amount that is owed is \$1135.20, leaving them a balance due of \$299.50."

**Amount in Dispute:** \$299.50

### Respondents' Position

"The original bill for dos 7/25/24 was received on 8/16/24 for CPT 07750 and paid as benefit maximum for the time period of occurrence has been reached also the charge for procedure exceeds the unit value and or the multiple procedure rules."

**Response Submitted by:** The Hartford

## 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 §134.203](#) sets out the fee guideline for professional medical services.
3. [28 TAC §134.225](#) sets the reimbursement guidelines for FCEs.

### **Adjustment Reasons**

The insurance carrier reduced the payment for the disputed service with the following claim adjustment codes:

- 163 – The charge for this procedure exceeds the unit value and/or the multiple procedure rules.
- 119 – Benefit maximum for this time period or occurrence has been reached.
- 133 – The disposition of this claim/service is pending further review.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 4150 – An allowance has been paid for a designated doctor examination as outlined in 134.204(J) for attainment of maximum medical improvement. An additional allowance is payable if a determination of the impairment caused by the compensable injury was also performed.
- PPRJ – Paid with prejudice.
- W3 - Bill is a reconsideration or appeal.
- 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.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.

### **Issues**

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

## **Findings**

1. The insurance carrier reduced the disputed service, 97750-FC, with reduction reason code 163 (description indicated above).

CPT Code 97750-FC is defined as a functional capacity evaluation.

On the disputed date of service, the requestor billed CPT code 97750-FC X 16 units.

The multiple procedure rule discounting applies to the disputed service.

Medicare Claims Processing Manual Chapter 5, 10.7-effective June 6, 2016, titled Multiple Procedure Payment Reductions for Outpatient Rehabilitation Services, states in pertinent part:

Full payment is made for the unit or procedure with the highest PE payment....

For subsequent units and procedures with dates of service on or after April 1, 2013, furnished to the same patient on the same day, full payment is made for work and malpractice, and 50 percent payment is made for the PE for services submitted on either professional or institutional claims.

To determine which services will receive the MPPR, contractors shall rank services according to the applicable PE relative value units (RVU) and price the service with the highest PE RVU at 100% and apply the appropriate MPPR to the remaining services. When the highest PE RVU applies to more than one of the identified services, contractors shall additionally sort and rank these services according to the highest total fee schedule amount, and price the service with the highest total fee schedule amount at 100% and apply the appropriate MPPR to the remaining services.

DWC finds that the Insurance Carrier's reimbursement reduction reason is supported.

2. The insurance carrier issued a payment in the amount of \$835.70 for the disputed service. The requestor is seeking additional reimbursement in the amount of \$299.50 for 16 units of CPT code 97750-FC rendered on July 25, 2024.

The following Texas Administrative Code (TAC) Rules apply to the reimbursement of 97750-FC:

28 TAC §134.203(b)(1) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

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. "

28 TAC §134.203 states in pertinent part, "(c) To determine the Maximum Allowable Reimbursement (MAR) for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year..."

On the disputed date of service, the requestor billed CPT code 97750-FC x 16 units.

As described in Finding #1 above, the multiple procedure discounting rule applies to the disputed service.

The MPPR Rate that contains the payments for 2024 services are found at [www.cms.gov/Medicare/Billing/TherapyServices/index.html](http://www.cms.gov/Medicare/Billing/TherapyServices/index.html).

To determine the MAR the following formula is used:

$(\text{DWC Conversion Factor} / \text{Medicare Conversion Factor}) \times \text{Medicare Payment} = \text{MAR}$ .

- MPPR rates are published by carrier and locality.
- Disputed service was rendered in zip code 78758, locality 31, Austin.
- The disputed date of service is July 25, 2024.
- The Medicare participating amount for CPT code 97750 in 2024 at this locality is \$34.78 for the first unit, and \$25.03 for each subsequent unit.
- The 2024B DWC Conversion Factor is 67.81
- The 2024B Medicare Conversion Factor is 33.2875
- Using the above formula, the MAR for the first unit is \$70.85 and \$50.99 for the subsequent 15 units, for a total MAR of \$835.68.
- The respondent paid \$835.70.
- The insurance carrier issued a payment in the amount of \$835.70.
- No additional reimbursement is recommended.

DWC finds that no additional reimbursement is due.

### **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 requestor has not established that additional reimbursement is not due.

### **Order**

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled

to \$0.00 additional reimbursement for the disputed service.

## Authorized Signature

_____	_____	April 9, 2025
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](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).