TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Courtney Brooke Thibodeaux, DC

Respondent Name
Harris County

MFDR Tracking Number
M4-25-2043-01

Carrier's Austin Representative
Box Number 21

DWC Date Received
May 1, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 27, 2024	97750 – FC	$198.03	$171.89

Requestor's Position

"The injured worker was referred by the Designated Doctor for a Functional Capacity Evaluation. The appointment took place on 08/27/2025 and the complete/clean bill was submitted to the carrier for reimbursement on 09/11/2025. According to the EOB received on 01/14/2025, the claim was being denied for '29 - The time limit for filling has expired'. On 01/14/2025, MET submitted a request for reconsideration with proof of timely submission and the reason(s) why MET stands by the claim as being complete and accurate. Apparently, the payor does not agree and has since issued a final decision to deny the request for payment."

Amount in Dispute: $198.03

Respondent's Position

"Following a thorough review of the claim history and the accompanying documentation, we have determined that providers failed to submit a completed bill. The CMS1500 submitted for processing is missing the required NPI number. (Box 32) (Box33)."

Response Submitted by: IMO

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §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 general rules 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.
4. 28 TAC §133.200 sets out the guidelines for insurance carrier's receipt of medical bills from health care providers.
5. 28 TAC §133.10 sets out the guidelines for healthcare providers required billing forms/formats.

Denial Reasons

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

- 29 – The time limit for filing has expired.

Issues

1. Did the requester submit the medical bill within the 95-day timely filing deadline?
2. Are Medicare's multiple procedure payment policies applicable to the disputed service?
3. Is the requester eligible for reimbursement for the specified doctor-referred Functional Capacity Evaluation (FCE)?

Findings

1. The requester is seeking reimbursement in the amount of $198.03 for a Functional Capacity Evaluation (FCE), billed under code 97750-FC, rendered on August 27, 2024. The insurance carrier denied the claim, citing that the time limit for filing has expired.

   A review of the medical documentation submitted by the healthcare provider reveals the following:

   - The initial medical bill was submitted on September 11, 2024. The insurance carrier did not respond to this submission.
   - The provider subsequently resubmitted the bill on December 11, 2024, and again on January 14, 2025.
   - The insurance carrier reviewed the second and third submissions and denied reimbursement, again citing that the time limit for filing had expired.

According to 28 TAC §133.200, insurance carriers are required to evaluate each received medical bill for completeness and take appropriate action. The regulation states:

> "(a) On receipt of medical bills submitted in accordance with §133.10 of this chapter (relating to Required Billing Forms/Formats), an insurance carrier must evaluate each medical bill for completeness as defined in §133.2 of this chapter… (c) The proper return of an incomplete medical bill in accordance with this section fulfills the insurance carrier's obligations with regard to the incomplete bill."

The insurance carrier received the initial bill on September 11, 2024, via fax. This bill was neither returned as incomplete nor audited in accordance with the requirements of 28 TAC §133.200. Therefore, the carrier's denial based on untimely filing is not supported.

2. CPT Code 97750-FC refers to a Functional Capacity Evaluation (FCE).

On the disputed date of service, the requester billed the CPT code 97750-FC for 3 units. The Multiple Procedure Payment Reduction (MPPR) applies to this service.

According to the **Medicare Claims Processing Manual, Chapter 5, Section 10.7**, effective June 6, 2016, titled *Multiple Procedure Payment Reductions for Outpatient Rehabilitation Services*:

> "Full payment is made for the unit or procedure with the highest Practice Expense (PE) payment. For subsequent units and procedures provided on or after April 1, 2013, to the same patient on the same day, full payment is made for work and malpractice components, while only 50% payment is made for the PE component for those services submitted on either professional or institutional claims."

To determine which services are subject to the MPPR, Medicare contractors rank the services based on their PE relative value units (RVUs). The service with the highest PE RVU is reimbursed at 100%, while the applicable MPPR is applied to the remaining services. If multiple services share the highest PE RVU, contractors then rank them by total fee schedule amount to determine which receives full reimbursement.

In this case, the billed units of 97750-FC are subject to MPPR, and reimbursement should be calculated accordingly.

2. The requestor is seeking reimbursement for a designated doctor-referred Functional Capacity Evaluation (FCE) performed on August 27, 2024. Since the insurance carrier's denial is not supported, the requestor is entitled to reimbursement.

The following TAC provisions govern the reimbursement of CPT code 97750-FC:

Under 28 TAC §134.203(b)(1), participants in the Texas workers' compensation system must follow Medicare payment policies for professional medical services. This includes applying Medicare's coding, billing, CCI edits, use of modifiers, bonus payments for HPSAs and PSAs, and other applicable payment policies effective on the service date, subject to any rule-based additions or exceptions.

The fee guideline for Functional Capacity Evaluations (FCEs) is outlined in 28 TAC §134.225. A maximum of three FCEs may be billed and reimbursed per compensable injury, excluding those ordered by the Division, which do not count toward this limit. FCEs must be billed using CPT code 97750 with the "FC" modifier and reimbursed according to §134.203(c). Reimbursement is limited to a maximum of four hours for the initial or Division-ordered test, two hours for interim tests, and three hours for discharge tests (unless it is also the initial test). Appropriate documentation is required.

Rule 28 TAC §134.203, to determine the Maximum Allowable Reimbursement (MAR) for professional services, Medicare payment policies are applied with minimal modifications. For Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery (in an office setting), the 2008 conversion factor is $52.83. For Surgery performed in a facility setting, it is $66.32. These conversion factors are updated annually based on the Medicare Economic Index (MEI), effective January 1 of each new calendar year.

On the disputed date of service, the requester billed CPT code 97750-FC x 3 units.

The MPPR Rate that contains the payments for 2024 services are found at www.cms.gov/Medicare/Billing/TherapyServices/index.html.

To determine the MAR the following formula is used:
(DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = MAR.

- MPPR rates are published by carrier and locality.
- Disputed service was rendered in zip code 77018, locality 04412, Houston 18.
- The disputed date of service is August 27, 2024.
- The Medicare participating amount for CPT code 97750 in 2024 at this locality is $34.36 for the first unit, and $25.01 for 2 subsequent units.
- The 2024 DWC Conversion Factor is 67.81
- The 2024 Medicare Conversion Factor is 33.2875
- Using the above formula, DWC finds the MAR is $171.89.
- The respondent paid $0.00.
- Reimbursement of $171.89 is recommended.

The division finds that the requester is entitled to $171.89. This amount is recommended.

Conclusion

The outcome of this medical fee dispute is determined by the evidence presented by both the requestor and the respondent during the adjudication process. While it is acknowledged that not all evidence may have been discussed in detail, all information submitted was duly considered in reaching a resolution.

DWC finds the requestor has established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed service. It is ordered that the Respondent must remit to the Requestor $171.89 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		June 12, 2025
Signature	Medical Fee Dispute Resolution Officer	Date

Your Right to Appeal

Either party to this medical fee dispute has the right to seek review of this decision under 28 TAC §133.307, which pertains to disputes filed on or after June 1, 2012.

A party wishing to seek 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 adhere to the instructions provided on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. You must submit your request to DWC within 20 days from the date you receive this decision. You can send your request via fax, mail, or by delivering it in person to DWC, using the contact details provided on the form or those of the field office managing your claim. It is imperative that your request is made within the specified timeframe to ensure proper handling of your case. Should you have any questions regarding DWC Form-045M, please contact CompConnection at 1-800-252-7031, option three or email CompConnection@tdi.texas.gov.

When seeking a review of the Medical Fee Dispute Resolution (MFDR) decision, the party initiating the review shall deliver a copy of the request to all other parties involved in the dispute simultaneously with the filing of the request with the Department of Workers' Compensation (DWC). Additionally, it is essential to include a copy of the Medical Fee Dispute Resolution Findings and Decision, along with any other required information as specified 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 tres o correo electronico CompConnection@tdi.texas.gov.