



Medical Fee Dispute Resolution Findings and Decision General Information

Requester Name

Reece Hayden DC

Respondent Name

Zurich American Insurance Co

MFDR Tracking Number

M4-25-2937-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

July 18, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 23, 2025	97750 FC x 16	\$301.21	\$0.00

Requester's Position

"The insurance carrier has not properly paid this claim in accordance with DWC Rules governing the specific services billed."

Amount in Dispute: \$301.21

Respondent's Position

The Austin carrier representative for Zurich American Insurance Co is Flahive, Ogden. The representative was notified of this medical fee dispute on July 21, 2025.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

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:

- 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.
- 163 – The charge for this procedure exceeds the unit value and/or the multiple procedure rules.
- TX119 – Benefit maximum for this time period or occurrence has been reached.

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 issued payment and reduced the charges with reduction code 163 (description indicated above).

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

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

Medicare Claims Processing Manual Chapter 5, 10.7-effective 06-06-16, 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. 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.

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

2. The insurance carrier issued a payment in the amount of \$869.19 for the disputed service. The requester is seeking additional reimbursement in the amount of \$301.21 for 16 units of CPT code 97750-FC rendered on April 23, 2025.

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

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."

DWC Rule 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."

DWC Rule 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 requester 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 file that contains the payments for 2025 services are found at 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 77042, locality 0441218, Houston.
- The disputed date of service is April 23, 2025.
- The MPPR rate for CPT code 97750 in 2025 at this locality is \$33.71 for the first unit, and \$24.46 for each subsequent unit.
- The 2024 DWC Conversion Factor is 70.18
- The 2025 Medicare Conversion Factor is 32.3465
- DWC finds the MAR is \$869.18.
- The respondent paid \$869.19.
- 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 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 additional reimbursement is not due.

Order

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

Authorized Signature

Signature

Medical Dispute Resolution Officer

September 30, 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. 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.