TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name
Pride, LLC

Respondent Name
Starr Specialty Insurance Co.

MFDR Tracking Number
M4-25-3403-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
August 26, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 24, 2025	97750-GO-FC	$625.00	$0.00

Requester's Position

"Please reconsider the enclosed explanation of benefits for the following current procedural terminology code. 97750 physical performance test or measurement of musculoskeletal function and the FC modifier is for functional capacity. Functional Capacity Evaluations can be done a maximum of three times for each compensable injury shall be billed and reimbursed. Reimbursement shall be for up to a maximum of four hours for the initial test, two hours for the interim test and three hours for the discharge test. Pre-Authorization is not required for the first 9 hours of functional capacity evaluation testing."

Amount in Dispute: $625.00

Respondent's Position

"Carrier maintains that reimbursement is not owed for these services. Provider has previously billed for physical performance testing on three other occasions. Functional capacity evaluations are limited for reimbursement to three per compensable injury pursuant to 28 TAC 134.225. Attached are EOBS for January 11, 2024, September 19, 2024, and May 20, 2025.
This submission is properly denied as coded."

Response Submitted by: Flahive, Ogden & Latson

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 Guidelines for professional medical services.

3. 28 TAC §134.225 sets out the Fee Guidelines for Functional Capacity Evaluations.

Denial Reasons

- 296 - SERVICE EXCEEDS MAXIMUM REIMBURSEMENT GUIDELINES.
- P12 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- 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.
- 193 - ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- W3 - BILL IS A RECONSIDERATION OR APPEAL.

Issues

1. Is the insurance carrier's denial of the disputed service supported?
2. Is the requester entitled to reimbursement for CPT code 97750-GO-FC?

Findings

1. The requester billed the insurance carrier for a functional capacity evaluation (FCE) under CPT code 97750-GO-FC x 5 units, rendered on July 24, 2025.

   A review of the explanation of benefits (EOB) submitted finds that the disputed service was denied payment due to "service exceeds maximum reimbursement guidelines."

   In its position statement the respondent asserts that the maximum of three FCEs had previously been billed by the requester and therefore, the service was properly denied. The respondent submitted EOBs from past dates of service in support of its denial reason. The respondent's position statement further asserts that the disputed date of service, July 24, 2025, has been appropriately denied for reimbursement.

28 TAC §134.225, 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. "

A review of the submitted documents finds sufficient evidence to support three previous FCE reimbursements for the same compensable injury as the FCE billed on the disputed date of service, July 24, 2025. No evidence was received to support that any of the prior FCEs or the one in question were ordered by the division.

Because the requestor did not support that an exception to the maximum number of FCEs applied in this case, DWC finds that the insurance carrier's denial of the disputed service, CPT code 97750-GO-FC, rendered on July 24, 2025, is supported.

2. The requester is seeking reimbursement in the amount of $625.00 for 5 units of CPT code 97750-GO-FC rendered on July 24, 2025. Because denial of the disputed service is supported, DWC finds that the requester is not entitled to reimbursement.

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 due for the service in dispute.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to reimbursement in the amount of $0.00 for the disputed date of service July 24, 2025.

Authorized Signature

		September 17, 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. 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 electronico CompConnection@tdi.texas.gov.