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

General Information

Requestor Name
Amanda McInis DC

Respondent Name
AIU Insurance Co.

MFDR Tracking Number
M4-26-0169-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
September 17, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 23, 2024	97750-FC	$559.84	$422.56
October 23, 2024	99080-73	$15.00	$15.00
	Total	$574.84	$437.56

Requestor's Position

"Service performed on 10/23/24 was for a Designated Doctor Referred FCE-functional capacity examination…"

Respondent's Position

The Austin carrier representative for AIU Insurance is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on September 29, 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.
4. 28 TAC Rule §127.10 sets out General Procedures for Designated Doctor Examinations

Denial Reasons

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

- 242 – Service not provided by network/primary care provider
- NNP – Non Network Provider

Issues

1. Is insurance carrier's denial supported?
2. What rules are applicable to reimbursement?
3. Is the work status report eligible for payment?
4. Is requester entitled to reimbursement?

Findings

1. The insurance carrier denied the disputed service, 97750-FC, as service not provided by network provider.

   DWC Rule 28 TAC Rule §127.10 (c) states "Additional testing and referrals. The designated doctor must perform additional testing when necessary to resolve the issue in question. The designated doctor must also refer an injured employee to other health care providers when the referral is necessary to resolve the issue in question, and the designated doctor is not qualified to fully resolve it."

   DWC Rule 28 TAC Rule §127.10 (c) (4) states " Any additional testing or referrals required for the evaluation of an injured employee under a certified workers' compensation network under Insurance Code Chapter 1305 or a political subdivision under Labor Code §504.053(b): (A) are not required to use a provider in the same network as the injured employee; and (B) are not subject to the network or out-of-network restrictions in Insurance Code §1305.101 (relating to Providing or Arranging for Health Care)."

   A review of the submitted documentation confirms that there is sufficient evidence to support the division's scheduling of a designated doctor examination with Dr. Charles Silver. Dr. Silver conducted the designated doctor examination and subsequently referred the claimant to the

requester for a Functional Capacity Evaluation (FCE) as part of the assessment. Therefore, the division concludes that the requester has adequately demonstrated that the disputed FCE was performed in conjunction with the designated doctor evaluation. Consequently, the denial based on the provider being out-of-network is not supported.

2. The requester seeks reimbursement of CPT Code 97750-FC functional capacity evaluation. The applicable DWC rules are found below.

   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.

   The applicable Medicare payment policy is found in the Medicare Claims Processing Manual Chapter 5, 10.7-effective June 6, 2016, titled Multiple Procedure Payment Reductions for Outpatient Rehabilitation Services at www.cms.gov.

   > *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 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 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… 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...

As described above, the multiple procedure discounting rule applies to the disputed service. The MPPR Rate File that contains the payments for 2024 services is 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 77022, locality 18, Houston.
- The disputed date of service is October 23, 2024
- The CMS Physician fee schedule allowable for CPT code 97750 in 2024 at this locality is $32.36 for the first unit, and $25.01 for each subsequent unit.
- The 2024 DWC Conversion Factor is 67.81
- The 2025 Medicare Conversion Factor is 33.2875
- Using the above formula, DWC finds the MAR is $65.02 for the first unit, and $50.95 for subsequent units x 7 = $356.64 for a total of $422.56.

3. The requester has also requested payment of code 99080-73 for a work status report. The applicable rules are, DWC Rule 28 TAC §129.5 (e)(g) states, "The doctor, delegated physician assistant, or delegated advanced practice registered nurse shall file the Work Status Report:

(1) after the initial examination of the injured employee, regardless of the injured employee's work status;
(2) when the injured employee experiences a change in work status or a substantial change in activity restrictions; and
(1) on the schedule requested by the insurance carrier, its agent, or the employer requesting the report through its insurance carrier, which shall not exceed one report every two weeks and which shall be based upon the doctor's, delegated physician assistants, or delegated advanced practice registered nurse's scheduled appointments with the injured employee.

(g) In addition to the requirements under subsection (e) of this section, the treating doctor, delegated physician assistant, or delegated advanced practice registered nurse shall file the Work Status Report with the insurance carrier, employer, and injured employee within seven days of the day of receipt of:

(1) functional job descriptions from the employer listing available modified duty positions that the employer is able to offer the injured employee as provided by §129.6(a) of this title (relating to Bona Fide Offers of Employment); or

(2) a required medical examination doctor's Work Status Report that indicates that the injured employee can return to work with or without restrictions.

Review of the submitted DWC073 indicates the return to work date with restrictions. Payment is recommended.

4. The total Maximum Allowable Reimbursement for code 97750-FC is $422.56. The fee guideline for code 99080-73 is $15.00 for a total allowed amount of $437.56. This amount is recommended.

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 requester has established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that AIU Insurance Company must remit to Amanda McInis DC $437.56 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

	Medical Fee Dispute Resolution Officer	December 29, 2025
Signature		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.