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

General Information

Requester Name
Marcus Hayes DC

Respondent Name
AIU Insurance Co

MFDR Tracking Number
M4-26-0251-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
September 25, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 4, 2025	97750-FC, 12 units	$877.68	$656.90

Requester's Position

"As states in the request for reconsideration, a FCE does not require pre-authorization as defined by Rule 134.600 because this is an examination and not treatment. ...FCEs shall be billed using CPT code 97750 with the modifier "FC". FCEs shall be reimbursed in accordance with (rule) 134.20 (c) (1) of this title..."

Amount in Dispute: $877.68

Respondent's Position

"We are attaching a copy of the provider's CMS 1500, the carrier's EOB dated September 18, 2025, the provider's request for reconsideration and the carrier's EOB dated September 25, 2025. Reimbursement has been denied. The EOB language explains the carrier's position. It remains the carrier's position that the provider is not entitled to reimbursement."

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 guideline for professional medical services.
3. 28 TAC §134.225 sets the reimbursement guidelines for FCEs.

Denial Reasons

The insurance carrier denied the disputed service(s) with the following claim adjustment codes.

- 197-5 – Pre-authorization/authorization/notification absent.
- 00663 – Reimbursement has been calculated based on the state guidelines.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 18 – Duplicate claim/service.

Issues

1. Is prior authorization required for code 97750-FC?
2. What rules are applicable to reimbursement?
3. Is the requester entitled to payment of disputed services?

Findings

1. The requester is seeking reimbursement of an FCE for date of service September 4, 2025. The insurance carrier denied the medical bill for lack of prior authorization. The submitted medical bill was for code 97750-FC which is specific to DWC Rule §134.225 that 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.

   This rule does not require prior authorization for division specific billing code 97750-FC

(functional capacity evaluations). Furthermore, no documentation was provided to support that the requester exceeded the DWC's maximum allowance of three FCEs per compensable injury. As a result, the insurance carrier's denial lacks sufficient justification. Reimbursement is recommended.

2. As outlined above, the reimbursement calculation is detailed in DWC Rule 28 TAC §134.203(c)(1)(2), which states, in relevant part: To determine the Maximum Allowable Reimbursement (MAR) for professional services, system participants must apply Medicare payment policies with minimal modifications. For service categories including Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery performed in an office setting, the established conversion factor is $52.83. The conversion factors specified in paragraph (1) of this subsection apply to the calendar year 2008. Conversion factors for subsequent years will be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the prior year's conversion factors, becoming effective on January 1 of each new calendar year.

   On the disputed date of service, the requester billed CPT code 97750-FC for 12 units, totaling 4 hours. Applicable to this service is 28 TAC §134.203(b)(1), which mandates that participants in the Texas workers' compensation system must adhere to Medicare payment policies for coding, billing, reporting, and reimbursement of professional medical services. This includes compliance with Medicare coding guidelines, billing procedures, Correct Coding Initiative (CCI) edits, modifiers, and other payment policies effective on the date the service is rendered, along with any additional rules or exceptions specified.

   Furthermore, the Medicare Claims Processing Manual, Chapter 5, Section 10.3.7, titled "Multiple Procedure Payment Reductions for Outpatient Rehabilitation Services," states:

   Medicare applies a multiple procedure payment reduction (MPPR) to the practice expense (PE) payment of select therapy services. The reduction applies to the HCPCS codes contained on the list of "always therapy" services (see section 20), excluding A/B MAC (B)-priced, bundled and add-on codes, regardless of the type of provider or supplier that furnishes the services.

   Medicare applies an MPPR to the PE payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. The MPPR applies to all therapy services furnished to a patient on the same day, regardless of whether the services are provided in one therapy discipline or multiple disciplines, for example, physical therapy, occupational therapy, or speech-language pathology.

   The multiple procedure payment (MPPR) reduction 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:

(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 77074, locality 04412 18, Houston.
- The disputed date of service is September 4, 2025.
- The Medicare allowed amount for CPT code 97750 in 2025 at this locality is $33.71 for the first unit, and $24.46 for each subsequent unit.
- The 2025 DWC Conversion Factor is 70.18
- The 2025 Medicare Conversion Factor is 32.3465
- The MAR for the first unit is $73.14 and $53.07 for the subsequent 11 units.
- Using the above formula, DWC finds the MAR is $656.90.

3. Review of information applicable to the disputed services and DWC rules the Maximum Allowable Rate (MAR) is $656.90. This amount is recommended.

Conclusion

The outcome of this medical 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 established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to reimbursement for disputed services. It is ordered that AIU Insurance Co must remit to Marcus Hayes DC, $656.90 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 17, 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 electronico CompConnection@tdi.texas.gov.