



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Reese Hayden DC

**Respondent Name**

New Hampshire Insurance Co

**MFDR Tracking Number**

M4-26-0304-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

September 30, 2025

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 18, 2025	97750-FC	\$301.21	\$0.00

### Requestor'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 provider billed for 16 units. The first unit is paid at \$73.14. Subsequent units are paid at \$53.07. The 15 units would be reimbursed at \$796.05. Added to the first unit of \$73.14 total \$869.19. That is the appropriate reimbursement rate. That is the rate that the carrier has paid. The provider is not entitled to any additional monies."

**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.

- 269 – This billing is for a service unrelated to the work illness or injury.
- 163 – The charge for this procedure exceeds the unit value and/or the multiple procedure rules.
- 309 – The charge for this procedure exceeds the fee schedule allowance.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

### Issues

1. What rules are applicable to reimbursement?
2. Is the requester entitled to payment of disputed services?

### Findings

1. The requester is seeking reimbursement of an FCE for date of service June 18, 2025. The insurance carrier reduced the payment amount based on the fee schedule.

DWC Rule §134.225 that states in pertinent parts, The following applies to functional capacity evaluations (FCEs 0... ...FCEs shall be billed using CPT code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c) of this title...

DWC Rule 28 TAC §134.203(c)(1)(2) which states in pertinent part,) To determine the Maximum Allowable Reimbursement (MAR) for professional services, system participants shall apply the Medicare payment policies with minimal modifications. 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... 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 requestor billed CPT code 97750-FC x 16 units. Also applicable to the disputed service is 28 TAC §134.203(b)(1) which 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... and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.

The Medicare Claims Processing Manual Chapter 5, 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 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](http://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 04412 18, Houston.
- The disputed date of service is June 18, 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 calculation for first unit  $70.18 / 32.3465 \times \$33.71 = \$73.14$

- The MAR calculation for subsequent fifteen units  $70.18/32.3465 \times 24.46 = \$53.07 \times 15 = \$796.04$
  - Using the above formula, DWC finds the MAR is \$869.18.
2. Review of information applicable to the disputed services and DWC rules the Maximum Allowable Rate (MAR) is \$869.18. The insurance carrier supports payment in the amount of \$869.19 on July 25, 2025 via check 0084713809. No additional payment 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 not established that additional reimbursement is due.

**Order**

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

**Authorized Signature**

		October 20, 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](http://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](mailto: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](mailto:CompConnection@tdi.texas.gov).