

## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requester Name**

Troy Robinson, D.C.

**Respondent Name**

City of Fort Worth

**MFDR Tracking Number**

M4-26-0305-01

**Carrier's Austin Representative**

Box Number 4

**DWC Date Received**

September 30, 2025

### Summary of Findings

| Dates of Service | Disputed Services                      | Amount in Dispute | Amount Due |
|------------------|----------------------------------------|-------------------|------------|
| July 19, 2025    | 97750-FC<br>Designated Doctor Referral | \$307.37          | \$0.00     |

### Requester's Position

"Carrier did not pay the bill properly regarding multiple procedure discounting."

**Amount in Dispute:** \$307.37

### Respondent's Position

"The City of Fort Worth, by and through its third-party administrator, Sedgwick, has reviewed the MDR Request and stands by its original payment determination for this date of service. The allowance was issued based on the cascade discount."

**Response Submitted by:** Ricky D. Green, PLLC

## 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 reduced the payment for the disputed service with the following claim adjustment codes:

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

### Issues

1. Are the Insurance Carrier's reimbursement reduction reasons supported?
2. Is the Requester entitled to additional reimbursement for CPT code 97750-FC?

### Findings

1. This dispute pertains to the reduction in payment of a functional capacity exam (97750-FC), referred to by a designated doctor and rendered on July 19, 2025. The insurance carrier issued payment in the amount of \$863.03 and reduced the remaining charges with reduction reason codes 163 (description indicated above). The requester is seeking additional reimbursement in the amount of \$307.37. Using the previously mentioned denial reduction code, the insurance carrier audited and upheld the reduction.

28 TAC §134.203(b)(1) states: For the coding, billing, reporting, and reimbursement of professional medical services within the Texas workers' compensation system, participants must adhere to the following requirements: Medicare payment policies shall apply, including coding guidelines, billing procedures, Correct Coding Initiative (CCI) edits, modifiers, bonus payments for Health Professional Shortage Areas (HPSAs) and Physician Scarcity Areas (PSAs), as well as any other payment policies effective on the date the service is rendered, subject to any additions or exceptions specified in the rules.

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.

The multiple procedure rule discounting applies to the disputed service.

Medicare Claims Processing Manual Chapter 5, 10.7-effective June 6, 2016, 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.

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 schedule fee amount, and price the service with the highest total fee schedule amount at 100% and apply the appropriate MPPR to the remaining services.

DWC finds that the Insurance Carrier's MPPR reimbursement reduction applies to the disputed services.

2. The requester billed \$1,170.40 for 16 units of CPT code 97750-FC rendered on July 19, 2025. The insurance carrier issued a payment in the amount of \$863.03 on August 7, 2025. The requester is seeking additional reimbursement in the amount of \$307.37.

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."

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 is 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:

$$(\text{DWC Conversion Factor} / \text{Medicare Conversion Factor}) \times \text{Medicare Payment} = \text{MAR}.$$

- The disputed date of service is July 19, 2025.
- MPPR rates are published by carrier and locality.
- Disputed service was rendered in zip code 75247, locality 11, Dallas.
- The Medicare participating amount for CPT code 97750 in 2025 at this locality is \$33.57 for the first unit, and \$24.28 for each subsequent unit.
- The 2025 DWC Conversion Factor is 70.18
- The 2025 Medicare Conversion Factor is 32.3465
- Using the above formula, DWC finds the MAR is \$72.83 for the first unit, and \$52.68 for each of the subsequent 15 units for a total MAR of \$863.03.
- The respondent paid \$863.03.
- 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 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

|                    |                                                 |                                   |
|--------------------|-------------------------------------------------|-----------------------------------|
| _____<br>Signature | _____<br>Medical Fee Dispute Resolution Officer | _____<br>November 6, 2025<br>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 three 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 electronico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).