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
Troy Robinson, D.C.

Respondent Name
Tarrant County Hospital District

MFDR Tracking Number
M4-26-0306-01

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
July 31, 2025	97750-FC x 16 units	$307.37	$0.00

Requester's Position

"The insurance carrier has not properly paid this claim in accordance with DWC Rule governing the specific services billed."

Amount in Dispute: $307.37

Respondent's Position

"The provider is not entitled to any additional monies. The provider billed for 16 units and has been reimbursed for them. The first quantity at the base rate of $72.83. additional quantities are paid at $52.68. There was one unit is $72.83 and 15 units at $52.68 for a total reimbursement of $863.03. We are attaching a copy of the formula used in making the calculation."

Response Submitted by: Flahive, Ogden & Latson

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §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) §133.305 Medical Dispute Resolution (MDR) General.
2. 28 TAC §133.307 Medical Fee Dispute Resolution.
3. 28 TAC §134.203 Medical Fee Guideline for Professional Services.
4. 28 TAC §134.225 Functional Capacity Evaluations.
5. 28 TAC §141.1 Requesting and Setting a Benefit Review Conference.

Denial Reasons

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

- 163 – This 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.
- 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 reimbursement reduction supported?
2. Is the requester entitled to additional reimbursement?

Findings

1. On the disputed date of service, the requester billed $1,170.40 for sixteen units of CPT code 97750-FC, representing a Functional Capacity Evaluation (FCE). The insurance carrier issued a payment of $863.03 and denied the remaining balance, citing denial reason codes 163 and 119. The requester seeks an additional payment in the amount of $307.37.

2. To determine whether the reimbursement was made in accordance with applicable fee guidelines, the Division of Workers' Compensation (DWC) applies 28 Texas Administrative Code (TAC) §134.203, which mandates the use of Medicare payment policies for coding, billing, reporting, and reimbursement in the Texas Workers' Compensation system.

   According to the Medicare Claims Processing Manual, Chapter 5, Section 10.7 (effective June 6, 2016), titled *Multiple Procedure Payment Reductions (MPPR) for Outpatient Rehabilitation Services*, the following guidelines apply:

- Full payment is made for the unit or procedure with the highest Practice Expense (PE) payment.
- For services provided on or after April 1, 2013, to the same patient on the same day, full payment is made for work and malpractice components, while only 50% of the PE component is paid for each additional unit or procedure.
- Services are ranked based on their PE Relative Value Units (RVUs), and the highest PE RVU is reimbursed at 100%. MPPR is then applied to subsequent units.

When multiple services have the same highest PE RVU, the one with the highest total fee schedule amount is paid in full, with MPPR applied to the rest.

1. The DWC determines that Multiple Procedure Payment Reduction (MPPR) applies to the disputed service. The insurance carrier's reduction is therefore supported. The carrier issued a payment of $863.07. The requester is now seeking additional reimbursement for the remaining amount of $307.37.

   The following Texas Administrative Code (TAC) rules are relevant:

   - 28 TAC §134.203(b)(1) requires adherence to Medicare payment policies for professional medical services, including coding, billing, and reimbursement.
   - 28 TAC §134.225 outlines billing and reimbursement guidelines specific to FCEs:
     - A maximum of three FCEs per compensable injury is reimbursable (excluding those ordered by the Division).
     - FCEs are to be billed using CPT code 97750 with modifier "FC".
     - Reimbursement is allowed for:
       - Up to four hours for an initial or Division-ordered test,
       - Two hours for an interim test,
       - Three hours for a discharge test, unless it is also the initial test.
     - Supporting documentation is required.
   - 28 TAC §134.203(c) outlines how to calculate the Maximum Allowable Reimbursement (MAR):
     - For Physical Medicine and Rehabilitation services, the 2025 DWC Conversion Factor is 70.18.
     - The 2025 Medicare Conversion Factor is 32.3465.
     - The MAR is calculated using the formula:

   (DWC Conversion Factor / Medicare Conversion Factor) × Medicare Payment = MAR
   Calculation of MAR:
   - Date of Service: July 31, 2025
   - Zip Code: 75247 (Locality 11 – Dallas)
   - Medicare Allowable Amounts for CPT 97750 in 2025:
     - First Unit: $33.57
     - Subsequent Units: $24.28

Using the MAR formula:

- First Unit:
  (70.18 / 32.3465) × 33.57 = $72.83
- Each of the 15 Subsequent Units:
  (70.18 / 32.3465) × 24.28 = $52.68

Total MAR:

- $72.83 + (15 × $52.68) = $863.01

Carrier Payment:

- Paid amount: $863.03

The insurance carrier paid $863.03, as a result no additional payment is due.

Conclusion

The DWC concludes that the insurance carrier's reimbursement reduction is supported under applicable Medicare and Texas Administrative Code guidelines. The requester has received payment for the 16 units of a functional capacity evaluation. No additional reimbursement is recommended.

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 services.

Authorized Signature

		October 31, 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 three, 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 512-804-4812.