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, DC

Respondent Name

Dallas Area Rapid Transit

MFDR Tracking Number

M4-26-0979-01

Insurance Carrier's Austin Representative

BOX 53 Hoffman Kelley LLP

DWC Date Received

December 3, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
May 31, 2025	97750-FC	$307.37	$0.00
	Total	$307.37	$0.00

Requester's Position

"Designated doctor examination referred diagnostic testing.. Incorrect reduction and/or denial".

Amount In Dispute: $307.37

Respondent's Position

"Respondent stands on its prior payment. Below is how the bill priced. Respondent has confirmed with the state that cascading is permitted".

Response Submitted By: Hoffman Kelley LLP

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code Section 413.031 and other applicable laws and rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) Section 133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC Section 134.225 sets out the guidelines for functional capacity evaluations.
3. 28 TAC Section 134.203 sets out the fee guidelines for professional medical fees.

Adjustment Reasons

- 163 – The charge for this procedure exceeds the unit value and/or the multiple procedure rules.
- 2008 – Additional payment made on appeal/reconsideration.
- 6060 – Based on additional information the claims examiner, we are recommending further payment be made for the above noted procedure code/codes.
- 119 – Benefit maximum for this time period or occurrence has been reached.
- P12 – Worker's compensation jurisdictional fee schedule adjustment.
- W3 – Bill is a reconsideration.
- N600 – Adjusted based on the applicable fee schedule for the region in which the service was rendered.

Issues

1. What is DWC considering in this medical fee dispute?
2. Is the requester entitled to additional reimbursement?

Findings

1. The requester is seeking additional reimbursement for a designated doctor–referred functional capacity evaluation performed on May 31, 2025. The insurance carrier issued payment in the amount of $863.03 and reduced the remaining balance pursuant to multiple procedure rules. As a result, the requester seeks an additional payment of $307.37.

2. The requester billed CPT code 97750-FC x 16 units, on May 31, 2025, in the amount of $1,170.40.

   The applicable reimbursement guideline for FCEs is found at 28 TAC Section 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 Section 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 Section 134.203(a)(5) defines "Medicare payment policies" as reimbursement methodologies, models, values, weights, coding, billing, and reporting payment policies as established by the Centers for Medicare and Medicaid Services (CMS) specific to Medicare.

28 TAC Section 134.203(b)(1) requires Texas workers' compensation system participants to apply Medicare payment policies for coding, billing, reporting, and reimbursement of professional medical services, including applicable coding edits, modifiers, and other payment policies effective on the service date, with any additions or exceptions noted in the rules.

Medicare Claims Processing Manual Chapter 5, 10.7-effective June 6, 2016, titled Multiple Procedure Payment Reductions (MPPR) 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 multiple procedure payment reduction (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".

The MPPR discounting rule applies to the disputed service, 97750-FC.

Per 28 TAC Section 134.203(c)(1), 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 $53.68.

The MAR is calculated using the formula:
(DWC Conversion Factor ÷ Medicare Conversion Factor) × Medicare Payment = Maximum Allowable Reimbursement (MAR).

- Date of service(s) in dispute: May 31, 2025
- A review of the medical bills finds that the disputed services were rendered in zip code 75247; the Medicare locality is 04412 11, "Dallas".
- The Medicare Participating amount for CPT code 97750 at this locality is $33.57 for the first unit and $24.28 for each of the subsequent 15 units.
- Using the above formula, the 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 $863.01.
- The requester seeks an additional payment of $307.37.
- The respondent paid $863.03.
- The requester is therefore not entitled to an additional payment for the disputed services.

The DWC finds that the requester has not established that additional reimbursement is due.

<u>Conclusion</u>

The outcome of this medical fee dispute is based on the evidence requester and the respondent presented 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 Sections 413.031 and 413.019, DWC has determined the requester is entitled to $0.00 reimbursement for the disputed services. .

Authorized Signature

		February 12, 2026
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 Section 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 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 this *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC Section 141.1(d).

Si prefiere hablar con una persona en español acerca de esta correspondencia, favor de llamar a 800-252-7031, opción tres o correo electronico CompConnection@tdi.texas.gov.