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

General Information

Requester Name

Healthcare Solutions

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-26-2207-01

Insurance Carrier's Austin Representative

BOX 54 Texas Mutual Insurance Co

DWC Date Received

April 8, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
January 8, 2026	97750-FC	$1,080.00	$0.00
	Total	$1,080.00	$0.00

Requester's Position

"I am writing to formally request your review and resolution of this fee dispute regarding the denial of payment for a Functional Capacity Evaluation (FCE) conducted on 01/08/2026. The claim was billed for a Functional Capacity Evaluation (FCE). No payment has been received for this claim. The carrier still owes $1080.00."

Amount In Dispute: $1,080.00

Respondent's Position

"HEALTHCARE SOLUTIONS billed for a functional capacity evaluation (FCE). The documentation does not support functional abilities testing, specifically cardiovascular endurance tests which measure aerobic capacity using a stationary bicycle or treadmill per Rule 134.225(g)(3)(C). Our position is that no payment is due."

Response Submitted By: Texas Mutual Insurance Company

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 134.203 sets out the fee guidelines for professional medical services.
3. 28 TAC Section 134.204 sets out medical fee guidelines for Workers' Compensation Specific Services.
4. 28 TAC Section 134.225 sets out the fee guidelines for functional capacity evaluations.

Adjustment Reasons

The insurance carrier denied payment for the disputed services with the following reasons:

1. CAC-18 – Exact duplicate claim/service.
2. 224 – Duplicate charge.

Issues

1. What is DWC considering in this medical fee dispute?
2. Is the insurance carrier's denial supported?
3. What rules apply to the services in dispute?
4. Is the requester entitled to reimbursement?

Findings

1. Healthcare Solutions is seeking reimbursement for a functional capacity evaluation (CPT Code 97750-FC) performed on January 8, 2026, in conjunction with a designated doctor examination to answer questions about return-to-work abilities. The Division will review the dispute based on the denial reasons outlined in the explanation of benefits (EOB) submitted to MFDR.
2. The requester seeks payment for a functional capacity evaluation ordered by a designated doctor. The insurance carrier denied the services, citing a duplicate charge and/or duplicate claim/service. Upon review of the submitted documentation, there is no evidence to support

the disputed service constitutes a duplicate claim, service, or charge. Therefore, the insurance carrier's stated denial reason is not substantiated. Additionally, no other EOBs were submitted by either party for consideration.

3. Reimbursement for CPT Code 97750-FC is governed by 28 TAC Section 134.225(g)(3)(C). The requester billed the service under CPT Code 97750, defined as "Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes," and appended modifier "FC," indicating a functional capacity evaluation.

   28 TAC Section 134.204(n)(3) requires the use of modifier "FC" when billing CPT Code 97750 for a functional capacity evaluation. Further, 28 TAC Section 134.225 outlines the requirements for FCEs, including documentation standards and required evaluation components. These components include: (1) a physical examination and neurological evaluation; (2) a physical capacity evaluation of the injured area; and (3) functional abilities testing, including submaximal cardiovascular endurance testing.

   Although the respondent denied reimbursement based on a duplicate claim/service, this rationale is not supported by the record. However, compliance with 28 TAC Section 134.225 requires that all mandated elements of an FCE be performed and documented. Review of the submitted FCE report indicates that one required component, specifically, submaximal cardiovascular endurance testing, was not included.

   Accordingly, despite the unsupported denial rationale, the documentation does not meet the regulatory requirements for reimbursement. Therefore, reimbursement is not recommended.

4. The respondent denied reimbursement for the FCE because key elements required by 28 TAC 134.225 were missing, specifically submaximal cardiovascular endurance tests. A review of the FCE report finds that the respondent's denial is supported. As a result, reimbursement is not recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence the 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 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

Signature	Medical Fee Dispute Resolution Officer	May 6, 2026 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.