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
Peak Integrated Healthcare

Respondent Name
Sompo America Fire & Marine Insurance

MFDR Tracking Number
M4-25-2714-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
June 27, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 4, 2025	97750-GP	$582.64	$441.58
March 6, 2025	99080-73	$15.00	$15.00
March 6, 2025	99213	$193.79	$193.79
March 27, 2025	99080-73	$15.00	$15.00
March 27, 2025	99213	$193.79	$193.79
	Total	$1000.22	$859.16

Requester's Position

The requester did not submit a position statement. They did submit a copy of their reconsideration dated May 13, 2025 regarding dates of service March 6th and 27th, 2025 that states, "The original bills were sent well before the time limit of 95 days for filing as demonstrated on the 2 forms of proof attached." The requesters submitted a copy of their reconsideration dated April 14, 2025 regarding date of service February 4, 2025 that states, "This was denied stating "benefit maximum has been reached. "This is incorrect. This is the first and only PPE performed for this patient and all necessary documentation for this allowable and necessary service has been attached. This should be paid in full."

Amount in Dispute: $1000.22

Respondent's Position

"The EOBs recommended no reimbursement, as the documentation was incomplete or deficient. The services in question required medical documentation to support the medical bills. Provider is not entitled to any payment."

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 reimbursement guidelines for professional medical services.

Denial Reasons

- 119- Benefit maximum for this time period or occurrence has been reached.
- 163-1 – Claim/service adjusted because the attachment referenced on the claim was not received.
- 251 – The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim.
- Submitted documentation indicates a PPE was performed not a FCE. Please reference Medical Fee Guidelines, Rule 134.202.e.4.
- 247 – A payment or denial has already been recommended for this service.
- B13-1 – Previously paid. Payment for this claim/service may have been provided in a previous payment.

Issues

1. Is the insurance carrier's denial for lack of documentation supported?
2. What rule is specific to reimbursement of physical performance evaluation?
3. Did the insurance carrier support a payment was made for the dates of service March 6th & 27th, 2025?
4. What is the rule applicable to reimbursement?
5. Is the requester entitled to additional reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Code 97750-GP rendered on February 4, 2025. The insurance carrier denied the disputed service stating the documentation a PPE was performed not an FCE.

   CPT Code 97750-GP is defined as "Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes."

   The requestor appended the "GP" modifier. The "GP" modifier is described as "Services delivered under an outpatient physical therapy plan of care."

   The DWC finds that the requestor billed and documented a physical performance test. As a result, the insurance carrier's denial reason is not supported, and the requestor is entitled to reimbursement pursuant to 28 TAC §134.203 for code 97750-GP.

2. The fee guideline for disputed service 97750-GP (x 8) is found at 28 TAC §134.203.

   28 TAC §134.203 (c)(1) states, "To determine the 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…"

   On the disputed dates of service, the requestor billed CPT code 97550-GP (x8). The multiple procedure rule discounting applies to the disputed service.

   Medicare Claims Processing Manual Chapter 5, 10.3.7-effective June 6, 2016, titled Multiple Procedure Payment Reductions for Outpatient Rehabilitation Services, states:

   > Full payment is made for the unit or procedure with the highest PE payment. For subsequent units and procedures with dates of service prior to April 1, 2013, furnished to the same patient on the same day, full payment is made for work and malpractice and 80 percent payment is made for the PE for services submitted on professional claims (any claim submitted using the ASC X12 837 professional claim format or the CMS-1500 paper claim form) and 75 percent payment is made for the PE for services submitted on institutional claims (ASC X12 837 institutional claim format or Form CMS-1450).
   >
   > 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 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 Rate File that contains the payments for 2025 services is found at https://www.cms.gov/Medicare/Billing/TherapyServices/index.html.

- The date of service is February 4, 2025.
- The DWC conversion factor for 2025 is 70.18.
- The Medicare conversion factor for 2025 is 32.3465.
- MPPR rates are published by carrier and locality.
- Review of Box 32 on the CMS-1500 finds that the services were rendered in zip code 75043.
- The Medicare participating amount for CPT code 97750 at this locality is $33.57 for the first unit, and $24.28 for subsequent units.

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = Maximum Allowable Reimbursement (MAR).

Using the above formula, the MAR is $72.83 for the first unit, and $52.68 x 7 units = $368.75 for the subsequent units, for a total of $441.58.

3. The insurance carrier denied the physician services and work status reports for dates of service March 6, 2025 and March 27, 2025 stating a payment had already been made on both dates of service. However, the insurance carrier did not support this statement with any proof of payment. These services will be reviewed pre applicable fee guidelines.
4. DWC Rule 28 Texas Administrative Code §134.203(c)(1) states in pertinent parts, "…To determine to MAR for professional services, system participants shall apply the Medicare payment policies with minimal modification…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 $53.68…"

The following formula represents the calculation of the DWC MAR at §134.203 (c)(1) & (2).

(DWC Conversion Factor ÷ Medicare Conversion Factor) x Medicare Payment = MAR. In this instance, 70.18/32.3465 x 89.32 (CMS fee schedule allowable for date of service and location) = $193.79 for date of service March 6, 2025 and $193.79 for March 27, 2025.

The requester is also seeking $15.00 for code 99808-73 for dates of service March 6, 2025 and March 27, 2025. The insurance carrier denied the claim stating a payment was already made. However, the insurance carrier did not support the previous payment. This service will be reviewed per applicable fee guidelines.

DWC Rule §129.5 (e) states, (e) The doctor, delegated physician assistant, or delegated advanced practice registered nurse shall file the Work Status Report:

(1) after the initial examination of the injured employee, regardless of the injured employee's work status;

(2) when the injured employee experiences a change in work status or a substantial change in activity restrictions; and

(1) on the schedule requested by the insurance carrier, its agent, or the employer requesting the report through its insurance carrier, which shall not exceed one report every two weeks and which shall be based upon the doctor's, delegated physician assistant's, or delegated advanced practice registered nurse's scheduled appointments with the injured employee.

(g) In addition to the requirements under subsection (e) of this section, the treating doctor,

delegated physician assistant, or delegated advanced practice registered nurse shall file the Work Status Report with the insurance carrier, employer, and injured employee within seven days of the day of receipt of:

(1) functional job descriptions from the employer listing available modified duty positions that the employer is able to offer the injured employee as provided by §129.6(a) of this title (relating to Bona Fide Offers of Employment); or

(2) a required medical examination doctor's Work Status Report that indicates that the injured employee can return to work with or without restrictions.

(j) ...The amount of reimbursement shall be $15. A doctor, delegated physician assistant, or delegated advanced practice registered nurse shall not bill in excess of $15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section.

Review of the submitted DWC073 for the disputed dates of service found the treating doctor did indicate the injured worker was able to return to work with work restrictions.

DWC finds the requirements of a work status report were met, $15.00 is due for date of service March 6, 2025 and $15.00 for March 27, 2025.

5. The total allowable DWC fee guideline reimbursement is as follows.

- Date of service February 4, 2025 - $441.58
- Date of service March 6, 2025 (99213) - $193.79
- Date of service March 27, 2025 (99213) - $193.79
- Date of service March 6, 2025 (99080-73) - $15.00
- Date of service March 27, 2025 (99080-73) - $15.00
- Total allowed = $859.16

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 established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to additional reimbursement for the disputed services. It is ordered that Sompo America Fire & Marine Insurance must remit to Peak Integrated Healthcare $859.16 applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		July 28, 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 3 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 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.