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

General Information

Requester Name
Peak Integrated Healthcare

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-25-2720-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
June 27, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 17, 2025	97750-GP	$457.13	$316.08

Requester's Position

"This bill was denied again for reason 'the therapy service code has been reduced per the Medicare multiple procedure rule for therapy services' this is incorrect as we billed 8 units =2 hours as stated in the report attached and should be paid in full."

Amount in Dispute: $457.13

Respondent's Position

"PEAK INTEGRATED HEALTHCARE billed for a physical performance evaluation (PPE). However, the documentation included in the DWC60 packet supports that this was a functional capacity evaluation (FCE). The documentation does not support the use of a stationary bicycle or treadmill per Rule 134.204(g)(3)(C). In additional the modifier FC was left off the bill which is required for a functional capacity exam per Rule 134.204(g). In addition, the documentation does not support the need for more than 30 minutes for this as no start and stop times are present in the documentation. 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 §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.

Denial Reasons

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

- CA-P12 – Workers' compensation jurisdictional fee schedule adjustment.
- CAC-W3, 350 – In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- G15 – Pricing is calculated based on the medical professional fee schedule value.
- J16 – This procedure code was ranked as the primary service when considered for multiple procedure rule for therapy services.
- J31 – The therapy service code has been reduced per the Medicare multiple procedure rule for therapy services.
- 863 – Documentation does not support the need for more than 30 minutes of time.
- 891 – No additional payment after reconsideration.

Issues

1. Has the requester been previously reimbursed for the disputed service?
2. Is the insurance carrier's reimbursement reduction reason supported?
3. Did the requester bill for a functional capacity evaluation or a physical performance evaluation?
4. Is the requester entitled to additional reimbursement for the CPT Code 97750-GP?

Findings

1. A review of the submitted documents finds that on the disputed date of service, March 17, 2025, the requester billed $582.64 for 8 units of CPT code 97750-GP. According to the Explanation of Benefits (EOB) provided, the insurance carrier issued a payment of $125.51 on May 6, 2025, for the service in question. Accordingly, the Division of Workers' Compensation (DWC) determines that the requester received a partial payment for the performance of the Physical Performance Evaluation (PPE) on March 17, 2025.

2. The insurance carrier issued a partial payment and reduced the remaining charges with the following reason codes:
    - G15 – Pricing is calculated based on the medical professional fee schedule value.
    - J16 – This procedure code was ranked as the primary service when considered for multiple procedure rule for therapy services.
    - J31 – The therapy service code has been reduced per the Medicare multiple procedure rule for therapy services.
    - 863 – Documentation does not support the need for more than 30 minutes of time.

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

    The requester appended the "GP" modifier to code 97750. The "GP" modifier is described as " "Services delivered under an outpatient physical therapy plan of care."

    28 TAC §134.203(b)(1), which applies to the reimbursement of 97750-GP, states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

    Medicare Claims Processing Manual Chapter 5, 10.3.7-effective June 6, 2016, titled Multiple Procedure Payment Reductions (MPPR) 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 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 MPPR discounting rule applies to the reimbursement of 8 units of CPT code 97750-GP rendered on March 17, 2025. Therefore, the MPPR taken by the insurance carrier is supported.

3. The insurance carrier states, "…the documentation included in the DWC60 packet supports that this was a functional capacity evaluation (FCE). The documentation does not support the use of a stationary bicycle or treadmill per Rule 134.204(g)(3)(C). In additional the modifier FC was left off the bill which is required for a functional capacity exam per Rule 134.204(g). In addition, the documentation does not support the need for more than 30 minutes for this as no start and stop times are present in the documentation."

   The bill in question does not include documentation supporting the use of a treadmill, which is required for a Functional Capacity Evaluation (FCE). However, the services billed were for a Physical Performance Test, not an FCE. The documentation provided supports the billing of CPT code 97750-GP, which corresponds to Physical Performance Testing. Therefore, the billing is supported based on the services rendered and documented. The insurance carrier's reason for denial or reduction is not supported, and the requester is entitled to reimbursement.

4. The requester seeks additional reimbursement for CPT code 97750-GP x 8 units rendered on March 17, 2025. CPT Code 97750-GP is defined as "Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes."

   Per CMS' Billing and Coding: Outpatient Physical and Occupational Therapy Services, Article ID A56566, effective October 1, 2020:

   > These tests and measurements are beyond the usual evaluation services performed. Examples of physical performance tests or measurements include isokinetic testing, Functional Capacity Evaluation (FCE) and Tinetti. This code may be used for the 6-minute walk test, with a computerized report of the patient's oxygen saturation levels with increasing stress levels, performed under a PT or OT plan of care on pulmonary rehabilitation patients.
   >
   > The therapy evaluation and re-evaluation codes are for a comprehensive review of the patient including, but not limited to, history, systems review, current clinical findings, establishment of a therapy diagnosis, and estimation of the prognosis and determination and/or revision of further treatment. CPT 97750 is intended to focus on patient performance of a specific activity or group of activities (CPT Assistant, December 2003).
   >
   > Written documentation must clearly identify the problem necessitating the test, detail the specific test performed, and include a separate report of the measurements. This report may contain torque curves and other graphical data, accompanied by an interpretation of the results.

97750 should not be used to bill for patient assessments/re-assessments such as ROM testing or manual muscle testing completed at the start of care (as this is typically part of the examination included in the initial evaluation) and/or as the patient progresses through the episode of treatment.

Supportive Documentation Requirements (required at least every 10 visits) for 97750

- Problem requiring the test and the specific test performed
- Separate measurement report, including any graphic reports
- Application to functional activity
- How the test impacts the plan of care

Review of submitted medical documentation finds that on the disputed date of service; the healthcare provider documented a two hour (8 units) physical performance evaluation of the same injured employee named on the medical bill. DWC finds that documentation of the disputed service, 97750-GP, rendered on March 17, 2025, is in compliance with requirements outlined above.

28 TAC §134.203 (c)(1) which applies to the reimbursement of the disputed service, states, "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…"

On the disputed date of service, the requester billed CPT code 97750-GP x 8 units. As demonstrated above, DWC finds that the MPPR rule applies to 97750-GP.

The MPPR Rate File that contains the payments for 2025 services is found at: www.cms.gov/Medicare/Billing/TherapyServices/index.html.

To determine the MAR the following formula is used:

(DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = MAR.

- The disputed date of service is March 17, 2025
- The disputed service was rendered in zip code 75211; the Medicare locality is 4412-11, 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 the subsequent 7 units.
- The 2025 DWC Conversion Factor is 70.18
- The 2025 Medicare Conversion Factor on this date of service is 32.3465.
- Using the above formula, the DWC finds the MAR is for the first unit is $72.83 and $52.68 for each of the 7 subsequent units for a total MAR amount of $441.59
- The respondent paid $125.51
- Additional reimbursement in the amount of $316.08 is recommended.

DWC finds that the requester is entitled to additional reimbursement.

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 that 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 reimbursement for the disputed services. It is ordered that the respondent must remit to the requester $316.08 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

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Authorized Signature

		August 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.