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
Cincinnati Indemnity Co.

MFDR Tracking Number
M4-25-2949-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
July 18, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 25, 2025	97750-GP	$582.64	$441.59

Requester's Position

"AFTER RECONSIDERATION WE AGAIN RECEIVED NO RESPONSE OF DENIAL OR PAYMENT FOR THESE AUTHORIZED SERVICES... The original bills were sent well before the time limit of 95 days of filing as demonstrated on the 2 forms of proof attached."

Amount in Dispute: $582.64

Respondent's Position

"Reimbursement was denied based on a missing or inaccurate modifiers on the billing documentation. It does not appear the service at issue was performed in a physical therapy setting. Contrary to the assertions raised by Peak Integrated Healthcare in its supporting documentation, Cincinnati Insurance Company did review and issue EORs in response to the billing received initially in March 2025, and on reconsideration in May 2025. Copies of those EORs are attached."

Response Submitted by: Burns Anderson Jury & Brenner, L.L.P.

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 guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system.

Adjustment Reasons

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

- 4 - THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING.

Issues

1. Is the insurance carrier's denial reason supported?
2. Is the requester entitled to reimbursement for CPT Code 97750-GP?

Findings

1. The insurance carrier denied reimbursement for disputed service, CPT Code 97750-GP x 8 units, rendered on February 25, 2025, based on a missing or incorrect modifier.

   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 CPT code 97750. The "GP" modifier indicates "Services delivered under an outpatient physical therapy plan of care."

   A review of the medical bill submitted finds that the code populated in box 24-B of the CMS 1500 medical billing form is place of service 11. Place of service 11 is defined as "Office-location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis." DWC finds that place of service 11, as defined, qualifies as an outpatient setting.

   A review of the submitted documentation finds that modifier GP appended to the service billed under CPT code 97750 is an allowed appropriate modifier for the service rendered on February 25, 2025. Consequently, the insurance carrier's reason for denial based on a missing or incorrect modifier is not supported.

2. The requester seeks reimbursement for CPT code 97750-GP x 8 units rendered on February 25, 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, revision effective January 1, 2025:

   > 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).
   >
   > There must be written evidence documenting the problem requiring the test, the specific test performed, and a separate measurement report. This report may include torque curves and other graphic reports with interpretation.
   >
   > 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 injured employee named on the medical bill. DWC finds that documentation of the disputed service, 97750-GP, rendered on February 25, 2025, is in compliance with the requirements outlined above.

   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, revised November 22, 2021, 10.7-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.

DWC finds that the MPPR discounting rule applies to the reimbursement of 8 units of CPT code 97750-GP rendered on February 25, 2025.

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 x 8 units.

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.

- MPPR rates are published by carrier and locality.
- The disputed date of service is February 25, 2025.
- The disputed service was rendered in zip code 75043, locality 11, Dallas; carrier 4412.

- 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 is 32.3465
- Using the above formula, DWC finds the MAR is $441.59 for 8 units of 97750-GP on the disputed date of service.
- Per submitted documentation, the respondent paid $0.00.
- Reimbursement is recommended in the amount of $441.59.

DWC finds that the requester is entitled to reimbursement in the amount of $441.59.

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 reimbursement is due in the amount of $441.59.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to reimbursement for the disputed date of service February 25, 2025. It is ordered that the Respondent, Cincinnati Indemnity Co., must remit to the Requester, Peak Integrated Healthcare, $441.59 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Ginger Ross	Ginger Ross	August 27, 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, 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.