



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requester Name**

Peak Integrated  
Healthcare

**Respondent Name**

Zurich American Insurance Co

**MFDR Tracking Number**

M4-26-0058-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

September 8, 2025

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 21, 2025	97110-GP	\$377.64	\$0.00
July 21, 2025	97112-GP	\$16.96	\$0.00
July 21, 2025	97110-GP	\$377.64	\$0.00
July 21, 2025	97112-GP	\$16.95	\$0.00
<b>Total</b>		\$789.20	\$0.00

### Requester's Position

The requester did not submit a position statement with this request for MFDR. They did submit a copy of a reconsideration dated August 19, 2025 and September 8, 2025 that states, "AFTER RECONSIDERATION WE WERE AGAIN DENIED FULL PAYMENT FOR AUTHORIZED SERVICES, STATING "ORIGINAL PAYMENT DECISION IS BEING MAINTAINED." THIS IS INCORRECT WE SHOULD BE PAID IN FULL FOR THIESE AUTHORIZED SERVICES.\*\*

**Amount in Dispute:** \$789.20

### Respondent's Position

"Our initial response to the above referenced medical fee dispute resolution is as follows: We have escalated the bills in question for manual review to determine if additional monies are

owed.”

**Response submitted by:** Gallagher Bassett

## **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 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.
2. [28 TAC §134.203](#) sets out the medical fee guideline for professional services.
3. [28 TAC §133.20](#) sets out the requirements of medical documentation.

### Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- 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.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 5283 – Additional allowance is not recommended as this bill was reviewed in accordance with state guidelines, usual and customary policies, provider’s contract, or carrier decision.
- B12-2 – Services not documented in patients’ medical records.
- 00663 – Reimbursement has been calculated based on the state guidelines.
- P12 – Workers’ compensation jurisdictional fee schedule adjustment.

### Issues

1. What services are in dispute?
2. Did the insurance carrier support the denial of code 97110-GP?
3. Did the insurance carrier’s payment of code 97112-GP conform to applicable fee guidelines?

4. Is the requester due additional payment?

Findings

1. The requester has submitted a request for MFDR for physical therapy services rendered in July of 2025. The insurance carrier denied the services based on benefit maximum and services not documented in the medical record. A review based on the information available is shown below.
2. The requester submitted a notice of approval for therapy services from July 15, 2025 through October 15, 2025 from Medinsights that approved code 97110 - Therapeutic procedure, 1 or more areas, each **15** minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility, however the number of units and number of visits is illegible on the document. DWC Rule 28 TAC §133.210 (b) states, When submitting a medical bill for reimbursement, the health care provider shall provide required documentation in legible form... As the authorized number of units/visits cannot be determined, the insurance carriers denial for benefit maximum is upheld for code 97110-GP for dates of service July 21, 2025 and July 23, 2025.

The insurance carrier also denied this claim line stating the services were not documented in the patient's medical records. Review of the Encounter note for each of the dates of service detailed the number of minutes spent on activities, but the date of the activity is illegible. The insurance carrier's denial is upheld.

3. The insurance company made a payment on code 97112 reducing the payment amount based on multiple procedure rules. The applicable DWC fee guideline for physical therapy is 28 TAC §134.203 (b) (1) which requires the application of Medicare payment policies applicable to professional services.

The applicable Medicare payment policy is found at [www.cms.gov](http://www.cms.gov), Medicare Claims Processing Manual, Chapter 5, Section 10.7 Multiple Procedure Payment Reductions for Outpatient Rehabilitation Services. *Medicare applies a multiple procedure payment reduction (MPPR) to the practice expense (PE) payment of select therapy services. The reduction applies to the HCPCS codes contained on the list of "always therapy" services (see section 20), excluding A/B MAC (B)-priced, bundled and add-on codes, regardless of the type of provider or supplier that furnishes the services. Medicare applies an MPPR to the PE payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedure*

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

- MPPR rates are published by carrier and locality.
- The services were provided in Garland, Texas.
- The carrier code for Texas is 4412 and the locality code for Garland is 11.

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

- DWC Conversion Factor for 2025 is 70.18
- Medicare Conversion Factor for 2025 is 32.3465
- Allowable for 1<sup>st</sup> unit of code 97112 - \$32.27
- Allowable for 2<sup>nd</sup> unit (MPPR rate applies) of code 97112 - \$24.45
- $70.18/32.3465 \times \$32.27 = \$70.01$
- $70.18/32.3465 \times \$24.45 = \$53.05$
- Total MAR  $\$70.01 + \$53.05 = \$123.06$
- Carrier supports payment in the amount of \$123.06 for code 97112 for date of service July 21, 2025 and July 23, 2025.

4. DWC reviewed the information available and found the denial based on benefit maximum and no documentation in medical record was upheld due to the documents submitted were illegible. The payment made for code 97112 was based on the applicable fee guideline. No additional payment is recommended.

### 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 not established that additional reimbursement is due.

### **Order**

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to \$0.00 additional reimbursement for the disputed services.

### **Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
October 29, 2025

\_\_\_\_\_  
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](http://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](mailto: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 electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).