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**

Zurich American Insurance Company

**MFDR Tracking Number**

M 4-26-1927-01

**Insurance Carrier's Austin Representative**

BOX 19 Flahive Ogden & Latson

**DWC Date Received**

March 10, 2026

## Summary of Findings

| Date(s) of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| November 17, 2025 | 97110-GP | $377.64 | $286.39 |
| November 17, 2025 | 97112-GP | $16.96 | $0.00 |
| November 18, 2025 | 97110-GP | $377.64 | $286.39 |
| November 18, 2025 | 97112-GP | $16.96 | $0.00 |
| November 20, 2025 | 97110-GP | $377.64 | $286.39 |
| November 20, 2025 | 97112-GP | $16.96 | $0.00 |
| November 24, 2025 | 97110-GP | $377.64 | $286.39 |
| November 24, 2025 | 97112-GP | $16.96 | $0.00 |
| December 2, 2025 | 97110-GP | $377.64 | $190.93 |
| December 2, 2025 | 97112-GP | $16.96 | $0.00 |
| | **Total** | 1973.00 | $1,336.49 |

## Requester's Position

The requester did not submit a position statement with this request for MFDR. They did submit a document titled, "Request for Reconsideration" dated March 10, 2026 that states, "These bills were denied in Full Payment for "Benefit Maximum for this time period or occurrence has been reached." This is incorrect and should all be paid in full."

**Amount In Dispute:** $1,973.00

## Respondent's Position

The Austin carrier representative for Zurich American Insurance Co is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on March 12, 2026.

Per 28 Texas Administrative Code Section 133.307(d)(1), if DWC does not receive the response within 14 calendar days of the dispute notification, then DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

## 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.

Adjustment Reasons

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

- 119 – Benefit maximum for this time period or occurrence has been reached.

- 193 – Original payment decision is being maintained. Upon review, it was determined that the claim was processed properly.

- B12 – Services not documented in patients medical records.

- 103 – The charge for this procedure exceeds the unit value and/or the multiple procedure rules.
- B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
- 247 – A payment or denial has already been recommended for this service.

Issues

1. What is DWC considering in this medical fee dispute?
2. Is the insurance carrier's denials supported?
3. What rule is applicable to reimbursement?
4. Has DWC determined whether reimbursement is due to the requester?

Findings

1. The requester is seeking full reimbursement of code 97110-GP for dates of service in November and December of 2025. They also are seeking additional payment for code 97112-GP for these same dates of service. The total amount in dispute is $1,973.00. DWC will review the denial and reduction of payment based on the applicable DWC rules and fee guidelines.
2. The denial reason of benefit maximum. 28 TAC Section 134.600 (c)(1)(B) and (p)(5)(A) states in pertinent parts, The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care; (5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (A) Level I code range for Physical Medicine and Rehabilitation, but limited to: (i) Modalities, both supervised and constant attendance;

   Review of the submitted documentation found a GB Care Utilization Review dated September 3, 2025 authorizing 12 visits for the time period of September 5, 2025 through December 5, 2025. Based on the evidence submitted with this dispute, the Division finds no limits were placed on the number of units associated with the authorized services.

   The denial based on service not documented in the medical record. 28 TAC 133.210(a) defines medical documentation as, Medical documentation includes all medical reports and records, such as evaluation reports, narrative reports, assessment reports, progress report/notes, clinical notes, hospital records and diagnostic test results. Review of the

information provided with this dispute included, "PEAK IHC ND" for the dates of service November 17, 2025 through December 2, 2025.

- Stretching – Foot ROM – 15
- Foot Stretching – 60, November 17-24, 2025
- Foot Stretching -30, December 2, 2025
- Band Exercises – 15, November 17-24, 2025
- Band Exercises – 10, December 2, 2025
- Total 90 units, for November 17-24, 2025, 55 units for December 2, 2025
- Theraball – 10, November 17, 2025 through December 2, 2025
- Heel Ball Roll – 5, November 17, 2025 through December 2, 2025
- One leg stands – 10, November 17, 2025 through December 2, 2025
- Total 25 units, November 17, 2025 through December 2, 2025.

The carrier's reduction based on benefit maximum and services not documented in the medical records are not supported for these dates of service.

3. The rules applicable to reimbursement are 28 TAC Section 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, 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 Dallas, Texas.
   - The carrier code for Texas is 4412 and the locality code for Dallas is 11.
   - The PE for code 97110 for this location is 0.43
   - The PE for code 97112 for this location is 0.48
   - Code 97112 has the highest PE and the first unit received full reimbursement $32.27.
   - Second unit code 97112 receives MPPR reduction and is reimbursed at $24.45
   - Code 97110 received MRRP reduction. Each unit is reimbursed at $22.00.

   28 TAC Section 134.203 states in pertinent part, (c) 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...

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year..."

(DWC Conversion Factor ÷ Medicare Conversion Factor) x Medicare Payment = MAR

- Code 97112 – 70.18/32.34365 x $32.27 = $70.01 + 70.18/32/3465 x $24.45 = $53.05. Total MAR code 97112 = $123.06
- Code 97110 – 70.18/32.3465 x $22.00 = $47.73 x 6 units = $286.39
- Code 97110 – 70.18/32.3465 x $22.00 = $47.73 x 4 units = $190.93

4. Based on review of the available information, the insurance carriers denial for benefit maximum and services not documented in the medical record are not supported. The MAR for the disputed service is as follows.

    - November 17, 2025 through November 24, 2025, 97110-GP 6 units $286.39 x 4 = $1,145.56
    - December 2, 2025, 97110-GP 4 units, $190.93
    - November 17, 2025, through December 2, 2025, 97112-GP 2 units $123.06 carrier paid $123.06 for each date of service no additional payment due.

    Total amount due to the requester, $1,145.67 + $190.93 = $1,336.49.

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 established that reimbursement is due.

## Order

Under Texas Labor Code Sections 413.031 and 413.019, DWC has determined the requester is entitled to reimbursement for the disputed services. It is ordered that Zurich American Insurance Co must remit to Peak Integrated Healthcare $1,336.49 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC Section 134.130.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | June 12, 2026<br>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.