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

American Zurich Insurance Company

MFDR Tracking Number

M4-26-2118-01

Insurance Carrier's Austin Representative

BOX 19 Flahive Ogden & Latson

DWC Date Received

March 30, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
October 28, 2025	99213	$193.79	$193.60
October 28, 2025	99080-73	$15.00	$15.00
November 11, 2025	99213	$193.79	$193.60
November 11, 2025	99080-73	$15.00	$0.00
December 2, 2025	99213	$193.79	$193.60
December 2, 2025	99080-73	$15.00	$0.00
December 9, 2025	97750-FC	$582.64	$441.59
December 29, 2025	99213	$193.79	$193.60
December 29, 2025	99080-73	$15.00	$0.00
January 12, 2026	99213	$204.90	$204.90

January 12, 2026	99080-73	$15.00	$0.00
	Total	$1,637.70	$1,435.89

Requester's Position

"After reconsideration we were again denied full payment for these dates of service stating 'entitlement to benefits' we have been treating and being paid for all visits."

Amount In Dispute: $1,637.70

Respondent's Position

"The provider is seeking payment of $1,622.70. The provider's bills have been denied for several reasons. The carrier's position remains consistent with its EOBs. We are attaching a copy of the carriers EOBs. The provider is not entitled to reimbursement."

Response Submitted By: Flahive, Ogden & Latson

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 133.210 sets out the requirements for medical bill processing by insurance carrier.
3. 28 TAC Section 134.203 sets out the fee guidelines for professional medical services.
4. 28 TAC Section 129.5 sets out the requirements for work status reports.
5. 28 TAC Section 134.225 sets out the fee guidelines for functional capacity evaluations.

Adjustment Reasons

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

1. P12 – Workers' compensation jurisdictional fee schedule adjustment.
2. P6 - Based on entitlement to benefits.

3. 219 – Based on extent of injury.
4. W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
5. 11 – The diagnosis is inconsistent with the procedure.

Issues

1. What is DWC considering in this medical fee dispute?
2. Did the insurance carrier submit a copy of a PLN in support of the denial reason?
3. Is the requester entitled to reimbursement for CPT Code 99213?
4. Is the requester entitled to reimbursement for CPT Code 99080-73?
5. Is the requester entitled to reimbursement for CPT Code 97750-FC?
6. Has the requester established that reimbursement is due for the disputed services?

Findings

1. The requester seeks reimbursement for evaluation and management services, work status reports, and functional capacity evaluation rendered on multiple dates between October 28, 2025, through January 12, 2026. The insurance carrier denied payment based on extent of injury.
2. The insurance carrier denied payment with code 219, based on extent of injury and code P6, based on entitlement to benefits.

   28 TAC Section 133.307(d)(2)(H), "Responses. Responses to a request for MFDR must be legible and submitted to the division and to the requester in the form and manner prescribed by the division… (H) If the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier must attach any related Plain Language Notice in accordance with §124.2 of this title (concerning Insurance Carrier Reporting and Notification Requirements)."

   Review of the documentation submitted by the parties, finds that the carrier did not provide documentation to the Division to support that it filed a Plain Language Notice (PLN) regarding the disputed conditions as required by Section 133.307(d)(2)(H).

   The respondent did not submit information to MFDR, sufficient to support that the PLN had ever been presented to the requester or that the requester had otherwise been informed of PLN prior to the date that the request for medical fee dispute resolution was filed with the DWC; therefore, the DWC finds that the extent of injury denial was not timely presented to the requester. Because the service in dispute does not contain an unresolved extent of injury

issue, this matter is eligible for adjudication of a medical fee under 28 TAC Section 133.307. For that reason, this matter is addressed pursuant to the applicable rules and guidelines

3. The requester seeks reimbursement for CPT Code 99213 for five dates of services spanning October 28, 2025, through January 12, 2026. As the insurance carrier's denial reasons are unsupported, DWC concludes that the requester is entitled to reimbursement under the applicable DWC statutes and rules..

   99213 – Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.

   28 TAC Section 134.203(b)(1) 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."

   28 Texas Administrative Code(TAC) Section 133.210(c)(1) sets out medical documentation requirements, stating in pertinent part "In addition to the documentation requirements of subsection (b) of this section, medical bills for the following services shall include the following supporting documentation: the two highest Evaluation and Management office visit codes for new and established patients: office visit notes/report satisfying the American Medical Association requirements for use of those CPT codes…"

   Medicare reimbursement policies require that the documentation of E/M services meet the American Medical Association (AMA) CPT Code Guidelines, which can be found at https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf.

   In summary, CPT code 99213 documentation must contain two out of three of the following elements: 1) low level of number and complexity of problems addressed 2) limited level of amount and/or complexity of data to be reviewed and analyzed 3) low risk of morbidity/mortality of patient management OR must document 20-29 minutes of total time spent on the date of patient encounter.

   An interactive E&M scoresheet tool is available at: www.novitas-solutions.com/webcenter/portal/MedicareJL/EMScoreSheet.

   A review of the submitted medical documentation finds that a low level of MDM was met in the elements of 1) Level of number and complexity of problems addressed 2) Amount or complexity of data reviewed and analyzed, for these reasons, DWC finds that medical documentation submitted met AMA criteria for reimbursement of CPT code 99213. As a result, the requester is entitled to reimbursement for CPT code 99213 rendered on dates

October 28, 2025, November 11, 2025, December 2, 2025, December 29, 2025, and January 12, 2026.

Under 28 TAC §134.203(c), the maximum allowable reimbursement (MAR) for professional services is determined by applying Medicare payment policies with minimal modifications. For Evaluation and Management (E/M), General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery services performed in an office setting, the applicable DWC conversion factor is used. The 2008 conversion factor was established at $52.83 for these services and $66.32 for Surgery performed in a facility setting. Conversion factors for subsequent years are adjusted annually based on the Medicare Economic Index (MEI) and become effective on January 1 of each new calendar year.

The MAR is calculated using the following formula:

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

For dates of service rendered in 2025:

- The disputed dates of service are October 28, 2025, November 11, 2025, December 2, 2025, and December 29, 2025.
- The disputed service was rendered in zip code 75043, locality 11, Dallas.
- The Medicare participating amount for CPT code 99213 in 2025 at this locality is $89.32.
- 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 $193.60 for CPT code 99213 on the disputed date of service.
- The respondent paid $0.00.
- The recommended amount for each disputed date of service in 2025 is $193.60.

- Total recommended amount $774.40

For date of service rendered in 2026:

- The disputed dates of service are January 12, 2026.
- The disputed service was rendered in zip code 75043, locality 11, Dallas.
- The Medicare participating amount for CPT code 99213 in 2026 at this locality is $94.96.
- The 2026 DWC Conversion Factor is 72.07
- The 2026 Medicare Conversion Factor is 33.4009
- Using the above formula, DWC finds the MAR is $204.90 for CPT code 99213 on the disputed date of service.
- The respondent paid $0.00.
- The recommended amount in 2026 is $204.90.

DWC finds that reimbursement is due for CPT Code 99213 for each disputed date of service.

4. The requester seeks reimbursement in the amount of $15.00 for five dates of service between October 28, 2025, through January 12, 2026.

   28 TAC Section 129.5 (j)(1) states, "…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. Doctors, delegated physician assistants, or delegated advanced practice registered nurses are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors, delegated physician assistants, or delegated advanced practice registered nurses billing for Work Status Reports as permitted by this section shall do so as follows: (1) CPT code '99080' with modifier '73' shall be used when the doctor, delegated physician assistant, or delegated advanced practice registered nurse is billing for a report required under subsections (e)(1), (e)(2), and (g) of this section."

   28 TAC Section 129.5(a)(2) states, "'substantial change in activity restrictions' means a change in activity restrictions caused by a change in the injured employee's medical condition which either prevents the injured employee from working under the previous restrictions or which allows the injured employee to work in an expanded and more strenuous capacity than the prior restrictions permitted (approaching the injured employee's normal job);
   (3) 'change in work status' means a change in the injured employee's work status from one of the three choices listed in subsection (a)(4) of this section to another of the choices in that subsection; and
   (4) the term 'work status' refers to whether the injured employee's medical condition:
   (A) allows the injured employee to return to work without restrictions (which is not equivalent to maximum medical improvement);
   (B) allows the injured employee to return to work with restrictions; or
   (C) prevents the injured employee from returning to work."

   A review of the submitted documentation finds the following:

   - Date of service October 28, 2025, the DWC 73 met the documentation requirements outlined in 28 TAC Section 129.5.

   - Date of service November 11, 2025, the DWC 73 did not meet the documentation requirements outlined in 28 TAC Section 129.5. There were no changes to the restrictions.

   - Date of service December 2, 2025, the DWC 73 did not meet the documentation requirements outlined in 28 TAC Section 129.5. There were no changes to the restrictions.

   - Date of service December 29, 2025, the DWC 73 did not meet the documentation requirements outlined in 28 TAC Section 129.5. There were no changes to the restrictions.

- Date of service January 12, 2026, the DWC 73 did not meet the documentation requirements outlined in 28 TAC Section 129.5. There were no changes to the restrictions.

The DWC finds that the requester is entitled to $15 for date of service October 28, 2025.

For the remaining dates of service listed above, the requester submitted insufficient documentation to support the billing of CPT code 99080-73. For this reason, reimbursement is not recommended.

5. The requester seeks reimbursement in the amount of $582.64 for a functional capacity evaluation (97750-FC) rendered on December 9, 2025.

   CPT Code 97750-FC is defined as a functional capacity evaluation.

   The applicable fee guideline for FCEs is found at 28 TAC Section 134.225, which states, "The following applies to functional capacity evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT code 97750 with modifier 'FC.' FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a division ordered test; a maximum of two hours for an interim test; and a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required."

   28 TAC Section 134.203 states in pertinent part, "(c) 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. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (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…"

   On the disputed date of service, the requester billed CPT code 97750-FC x 8 units

   28 TAC Section 134.203(b)(1) states: For coding, billing, reporting, and reimbursement of professional medical services within the Texas workers' compensation system, participants must adhere to the following requirements: Medicare payment policies shall apply, including coding guidelines, billing procedures, Correct Coding Initiative (CCI) edits, modifiers, bonus payments for Health Professional Shortage Areas (HPSAs) and Physician Scarcity Areas (PSAs), as well as any other payment policies effective on the date the service is rendered, subject to any additions or exceptions specified in the rules.

The multiple procedure rule discounting applies to the disputed service.

Medicare Claims Processing Manual Chapter 5, 10.7-effective June 6, 2016, titled Multiple Procedure Payment Reductions for Outpatient Rehabilitation Services, states in pertinent part:

> Full payment is made for the unit or procedure with the highest PE payment….
> 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 carrier's MPPR-based payment reduction applies to the disputed services.

As described above, the multiple procedure discounting rule applies to the disputed service.

The MPPR Rate File that contains the payments for 2025 services 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 December 9, 2025
- MPPR rates are published by carrier and locality.
- Disputed service was rendered in zip code 75043, locality 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 each subsequent unit.
- 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 $72.83 for the first unit, and $52.68 for each of the subsequent 7 units for a total MAR of $441.59.
- The respondent paid $0.00.
- The recommended reimbursement is $441.59.

DWC finds that reimbursement in the amount of $441.59 is due.

6. DWC concludes that the requester is entitled to a total reimbursement amount of $1,435.89.

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 American Zurich Insurance Company must remit to Peak Integrated Healthcare $1,435.89 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 8, 2026 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.