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

LM Insurance Corp

MFDR Tracking Number

M4-26-2702-01

Insurance Carrier's Austin Representative

BOX 60 Downs Stanford PC

DWC Date Received

March 29, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
April 21, 2026	97110-GP	$94.02	$5.70
April 21, 2026	97112-GP	$19.83	$2.98
	Total	$113.85	$8.68

Requester's Position

"After reconsideration we are again denied full payment stating 'no additional payment allowed.' This is incorrect and we have not been paid in full."

Amount In Dispute: $113.85

Respondent's Position

"The Carrier allowed reimbursement of $282.60 for CPT code 97110 and $121.59 for CPT code 97112. The amount billed was reduced due to cascading. The rule states PT cascade discount applied to codes with starred flag set to 5. In conclusion, Requestor is not owed any additional reimbursement for the physical therapy as the proper amount was paid per the Medicare rules fee guidelines."

Response Submitted By: Downs & Stanford, P.C.

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 guideline for professional medical services.

Adjustment Reasons

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

1. 163 – The charge for this procedure exceeds the unit value and/or the multiple procedure rules.

2. 119 – Benefit maximum for this time period or occurrence has been reached.

3. OA – Other adjustment.

4. 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

5. 2005 – No additional reimbursement allowed after review of appeal/reconsideration.

6. 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. What is DWC considering in this medical fee dispute?

2. Is the requester entitled to additional reimbursement?

Findings

1. The requester seeks additional reimbursement for CPT Codes 97110-GP and 97112-GP rendered on April 21, 2026. The insurance carrier reduced the disputed services with reduction codes indicated above.

   The requester seeks additional payment in the amount of $94.02 for CPT code 97110, and $19.83 for CPT code 97112.

2. The carrier reduced the allowed amount based on the workers compensation fee schedule and multiple procedure payment rules.

   TAC Section 134.203(a)(5) states, "'Medicare payment policies' when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   The requester billed the following CPT Codes 97710-GP x 6 units and 97112-GP x 2 units. The definition of each code is indicated below:

   - CPT code 97110 - "Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility."
   - CPT Code 97712 – "Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities."

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

   Medicare Claims Processing Manual, Chapter 5, Section 10.3.7—effective June 6, 2016, titled *Multiple Procedure Payment Reductions for Outpatient Rehabilitation Services*, outlines the following policy:

   - Full payment is made for the procedure or unit with the highest Practice Expense (PE) payment.
   - For subsequent units or procedures with dates of service on or after April 1, 2013, provided to the same patient on the same day, payment is:
     - Full payment for work and malpractice expenses.
     - 50% payment of the PE component for services billed on either professional or institutional claims.

   To determine which services are subject to the Multiple Procedure Payment Reduction (MPPR), contractors rank services based on their PE relative value units (RVUs). The service with the highest PE RVU receives 100% payment, while the 50% MPPR is applied to the remaining services.

   If multiple services share the highest PE RVU, they are further ranked by the highest total fee schedule amount. The service with the highest fee schedule receives full payment, and the MPPR applies to the rest.

A review of Medicare policies confirms that the MPPR applies to the Practice Expense component of certain time-based physical therapy codes when multiple units or procedures are performed on the same day for the same patient. Medicare publishes an annual list of codes subject to this policy. The DWC finds that both CPT code 97110 and 97112 are subject to the MPPR policies and are ranked as follows:

CPT Code	Practice Expense
97110	0.41
97112	0.47

As shown above, CPT Code 97112 has the highest PE payment amount therefore, the reduced PE payment applies to the remaining units for both CPT 97112 (1 unit) and 97110 (6 units).

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..."

The MPPR Rate File that contains the payments for 2026 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 zip code 75043, Dallas, TX.
- The carrier code for Texas is 4412 and the locality code for Dallas is 11.

CPT Code	Medicare Fee Schedule (1st unit)	MPPR for subsequent units
97110		$22.27
97112	$32.77	$24.96

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = Maximum Allowable Reimbursement (MAR).

- The 2026 DWC Conversion Factor is 72.07
- The 2026 Medicare Conversion Factor is 33.4009

Description	Qty	Rate	MAR Amount
97112 MAR – 1st Unit	1	$70.71	$70.71
97112 MAR – Sub. Units	1	$53.86	$53.86
97110	6	$48.05	$288.30
		Total MAR	$412.87

The MAR for CPT code 97112 is $124.57. The insurance carrier paid $121.59; therefore, an additional payment of $2.98 is recommended. The MAR for CPT code 97110 is $288.30. The insurance carrier paid $282.60; therefore, an additional payment of $5.70 is recommended.

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 additional reimbursement is due.

Order

Under Texas Labor Code Sections 413.031 and 413.019, DWC has determined the requester is entitled to additional reimbursement for the disputed services. It is ordered that LM Insurance Corp must remit to Peak Integrated Healthcare $8.68 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 17, 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.