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
Old Republic Insurance Co

MFDR Tracking Number
M4-25-2365-01

Carrier's Austin Representative
Box Number 44

DWC Date Received
May 27, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 1, 2025	97110-GP	$377.64	$286.39
April 1, 2025	97112-GP	$16.96	$0.00
April 2, 2025	97110-GP	$377.64	$286.39
April 2, 2025	97112-GP	$16.96	$0.00
	Total	$789.20	$572.78

Requester's Position

"These bills were denied FULL PAYMENT for 'exceeds fee schedule or mppr .' This is INCORRECT. WE ARE AUTHORIZED TO TREAT. Therefore, this date of service should be paid in full as all others. We requested authorization for CPT codes 97110 AND 97112 before scheduling treatment. The units are for 6 units of 97110 and 2 units for 97112."

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. We will provide a supplemental response once the bill auditing company has finalized their review."

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 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203 sets out the fee guideline for professional medical services.
3. 28 TAC §134.600 sets out the preauthorization guidelines for specific treatments and services.

Denial Reasons

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

- 5405 – This charge was reviewed through the clinical validation program.
- 5721 – To avoid duplicate bill denial for all reconsiderations/adjustments/additional payment requests, submit a copy of this EOR or clear notation that a recon.
- 90405, 119 – Benefit maximum for this time period or occurrence has been reached.
- B12 – Services not documented in patients medical records.
- 163 – The charge for this procedure exceeds the unit value and/or the multiple procedure rule.
- 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.

Issues

1. What are the services in dispute?
2. Are the Insurance Carrier's denial reasons supported?
3. What are the applicable rules and guidelines?
4. Is the Requester entitled to reimbursement?

Findings

1. The requester seeks reimbursement for CPT Code 97110-GP and additional reimbursement for CPT Code 97112-GP rendered on April 1, 2025, and April 2, 2025. The insurance carrier denied and reduced the disputed services with the reduction codes indicated above.

   The requester seeks additional payment in the amount of $16.96 for CPT code 97112, and $377.64 for CPT code 97110.

2. The insurance carrier denied payment of CPT code 97110-GP (6 units) on the grounds that the services were not documented in the patient's medical records. A review of the submitted medical records confirms that the requester did document 6 units of CPT code 97110 for dates of service April 1, 2025, and April 2, 2025. Since the services were clearly documented in the medical records for the dates in question, the denial based on "B12" is not supported.

   The insurance carrier also denied payment of CPT code 97110-GP with denial reduction codes 119, 90409, citing that the benefit maximum had been reached.

   The requester obtained preauthorization from MedInsight for the following:

   - CPT code 97110 x 6 units
   - CPT code 97112 x 2 units
   - These services were authorized to be rendered between March 17, 2025, and June 17, 2025.

   The disputed services (97110-GP) and (97112-GP) were delivered within the authorized date range, and no evidence was submitted by the insurance carrier to show that the benefit maximum had been reached. In the absence of documentation supporting that the benefit maximum had been reached, and given that preauthorization was obtained, the denials under codes 119 and 90409 are not supported. Therefore, the requester is entitled to reimbursement.

3. 28 TAC §134.203(a)(5) requires that reimbursement methodologies be aligned with Medicare payment policies, including billing and reporting guidelines.

   CPT Codes definitions:

   - 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 97112 – "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."

   Modifier GP was appended to indicate that the services were delivered under an outpatient physical therapy plan of care.

   28 TAC §134.600(p) states that preauthorization is required for physical therapy services beyond the first six visits post-injury or surgery, except when services fall within the first two weeks after the injury or surgery and are among the first six visits

   A review of the preauthorization issued by MedInsight confirms the requester had obtained preauthorization for the services provided within the relevant timeframe.

   The DWC finds that based on the documentation, applicable rules, and preauthorization:

   - The services were documented in the medical record.

- The services were preauthorized and delivered within the approved timeframe.
- The insurance carrier did not provide sufficient evidence to support either denial reasons.

The requester is therefore entitled to reimbursement for CPT code 97110-GP x 6 units, in accordance with 28 TAC 134.203.

4. 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	0.43
97112	0.48

    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 (2 units) and 97110 (6 units).

28 TAC §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 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 zip code 75043, Dallas.
- 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		$22.00
97112	$32.27	$24.45

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

- The 2025 DWC Conversion Factor is 70.18
- The 2025 Medicare Conversion Factor is 32.3465
- Using the above formula, the DWC determined the following:

Date of Service	CPT Code	# Units	CMS Payment	MAR	Insurance Carrier Paid	Amount Sought	Recommended Amount
April 1, 2025	97110	6	$22.00	$47.73 x 6 = $286.39	$0.00	$377.64	$286.39
April 1, 2025	97112	2	1st Unit $32.27 2nd Unit $24.45	1st Unit $70.01 2nd Unit $53.05 = $123.06	$123.06	$16.96	$0.00
April 2, 2025	97110	6	$22.00	$47.73 x 6 = $286.39	$0.00	$377.64	$286.39
April 2, 2025	97112	2	1st Unit $32.27 2nd Unit $24.45	1st Unit $70.01 2nd Unit $53.05 = $123.06	$123.06	$16.96	$0.00

The requester is entitled to reimbursement of $572.78 for dates of service April 1, 2025, and April 2, 2025.

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 established that reimbursement of $572.78 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requester $572.78 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		August 22, 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, please 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.