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 Company

MFDR Tracking Number
M4-25-2444-01

Carrier's Austin Representative
Box Number 44

DWC Date Received
June 3, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
2/20/25	97110-GP x 6	$377.64	$0.00
2/20/25	97112-GP x 2	$16.96	$0.00
3/4/25	97110-GP x 6	$377.64	$0.00
3/4/25	97112-GP x 2	$16.96	$0.00
3/6/25	97110-GP x 6	$377.64	$0.00
3/6/25	97112-GP x 2	$16.96	$0.00
3/18/25	97110-GP x 6	$377.64	$0.00
3/18/25	97112-GP x 2	$16.96	$0.00
	Total	$1,578.40	$0.00

Requester's Position

"These bills were denied again for full payment after reconsideration for reason 'The attachment/ other documentation that was received was incomplete or deficient.'... Also, I am including a copy of service date 02/13/2025 that was paid for the same service."

Amount in Dispute: $1,578.40

Respondent's Position

"Supplemental response will be provided once the bill auditing company has finalized their review. Attached is a copy of all bills received to date, and their corresponding EOB's and payment detail."

Response Submitted by: Gallagher Bassett

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §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) §133.305 sets out the procedures for resolving medical disputes.
2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 TAC §134.203 sets out the fee guideline for professional medical services.
4. 28 TAC §134.600 sets out the Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care.

Denial Reasons

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

- 251 – The attachment/other documentation that was received was incomplete or deficient. Then necessary information is still needed to proceed with the claim.
- W3 – In accordance with TDI-DWC rule 134.804. This bill has been identified as a request for reconsideration or appeal.
- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
- 197 – Precertification/authorization/notification/pre-treatment absent.
- P12, 00663 – Workers' compensation jurisdictional fee schedule adjustment.
- XXU00 – There was no UR procedure/treatment request received.
- XXG15 – Pricing is calculated based on the medical professional fee schedule value.
- XX039 – Denial based upon review of documentation submitted.
- XX001 – Additional allowance recommended. This has been re-evaluated, and an additional allowance is recommended.

Issues

1. Did the respondent submit a supplemental response for consideration in this review?
2. What are the services in dispute?
3. Is the insurance carrier's denial reasons supported for CPT code 97110?
4. Is the insurance carrier's reduction of payment supported for CPT code 97112?
5. Is the requester entitled to additional reimbursement?

Findings

1. Gallagher Bassett, acting on behalf of Old Republic Insurance Company, stated that a supplemental response would be provided once the bill auditing company completed its review. They also indicated that all bills and their corresponding EOBs and payment details were attached.

   However, as of the date of this review, no supplemental response has been submitted, and the referenced documentation (including bills and EOBs) was not provided. Therefore, this decision is based solely on the documentation submitted with the Medical Fee Dispute Resolution (MFDR) request.

2. This dispute concerns the non-payment of CPT code 97110 and the reduced payment of CPT code 97112, totaling $1,578.40 for services rendered on February 20, March 4, March 6, and March 18, 2025. The dispute pertains exclusively to CPT codes 97110 and 97112. Although the requester listed CPT codes 99213 and 99080-73 in the table of disputed services, no reimbursement is sought for these codes; therefore, they are not addressed in this dispute.

   The fee guidelines applicable to this service are set forth in 28 TAC §134.203(a)(5), which defines "Medicare payment policies" as the reimbursement methodologies, models, values, weights, coding, billing, and reporting payment procedures established by the Centers for Medicare and Medicaid Services (CMS) specifically for Medicare.

   28 TAC §134.203(b)(1) requires Texas workers' compensation system participants to apply Medicare payment policies for coding, billing, reporting, and reimbursement of professional medical services, including applicable coding edits, modifiers, and other payment policies effective on the service date, with any additions or exceptions noted in the rules.

   The following identifies the CPT codes in dispute:

   - CPT Code 97110 – Therapeutic Exercise: Disputed for non-payment.
   - CPT Code 97112 – Neuromuscular Reeducation: Disputed for partial payment.

3. The insurance carrier denied payment for CPT code 97110 on all disputed dates of service, citing the following denial codes:

   - Code 197 – Preauthorization not obtained.
   - Code 251-1 – Incomplete or deficient documentation.
   - Proprietary Code XXU00

Under 28 TAC §134.600(p)(5), therapeutic procedures such as CPT 97110 require preauthorization. A preauthorization letter dated February 14, 2025, issued by MedInsight, was provided; however, the date range was illegible, making it difficult to verify whether the services fell within the authorized period or if the benefit maximum had been exceeded.

According to 28 TAC §133.307(c), all requests and supporting documentation must be legible. Since the illegibility of the preauthorization document prevents validation, the Division concludes that the carrier's denial is supported, and reimbursement is not recommended for CPT code 97110.

4. The requester billed CPT code 97112 (Neuromuscular Reeducation) for two units per date of service, at $140.02. The insurance carrier paid $123.06 and reduced the balance under denial code P12, citing a fee schedule adjustment.

   In accordance with:

   - 28 TAC §134.203(b)(1) – Reimbursement must follow Medicare payment policies.
   - Medicare Claims Processing Manual, Chapter 5, Section 10.7 – MPPR (Multiple Procedure Payment Reduction) applies.
   - 28 TAC §134.203(c)(1) – The Maximum Allowable Reimbursement (MAR) is calculated as: (DWC Conversion Factor ÷ Medicare Conversion Factor) × Medicare Payment = Maximum Allowable Reimbursement (MAR).
   - Procedure Code: 97112 x 2 units
   - Dates of service in dispute: February 20, 2025; March 4, 2025; March 6, 2025 and March 18, 2025.
   - The 2025 DWC Conversion Factor is 70.18
   - The 2025 Medicare Conversion Factor is 32.3465
   - A review of the medical bills finds that the disputed services were rendered in zip code 75211; the Medicare locality is "Dallas."
   - The Medicare Participating amount for CPT code 97112 at this locality is $32.27 for the first unit and $24.45 for each subsequent unit.
   - Using the above formula, the DWC finds the MAR is $70.01 for the first unit and $53.05 for the subsequent unit for a total MAR of $123.06.

   The insurance carrier's payment of $123.06 per date of service is consistent with the MAR, and the MPPR was correctly applied. Therefore, the reduction is supported, and no additional reimbursement is due.

5. The DWC concludes the following:
    - CPT 97110: Denied due to lack of verifiable preauthorization documentation. Reimbursement is not recommended.
    - CPT 97112: Paid in accordance with applicable Medicare-based fee guidelines. No additional reimbursement is recommended.

   The DWC finds that based on the documentation and applicable rules, the requester has not established entitlement to reimbursement for the disputed services.

Conclusion

The resolution of this medical fee dispute is determined by the evidence provided by both the requester and the respondent during the adjudication process. While not all evidence may have been thoroughly discussed, all relevant information was considered in reaching a decision.

The DWC finds the requester has not established that reimbursement is due.

Order

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

Authorized Signature

		October 21, 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 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 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 512-804-4812.