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
Hartford Insurance Co of Illinois

MFDR Tracking Number
M4-25-2690-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
June 26, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 12, 2025	97116 / Gait Training	$170.54	$95.26

Requester's Position

"Carrier is not reimbursing according to authorization our facility received from the carrier."

Amount in Dispute: $170.54

Respondent's Position

"The original bills for dos 3/12/25 was received on 3/24/25 under control number … and paid $205.54 as benefit maximum for this time period or occurrence has been reached. Bill processed on 3/31/25."

Response Submitted by: The Hartford

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 guidelines for specific treatments and services.

Denial Reasons

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

- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- W3 – Bill is a reconsideration or appeal.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 1115 – We find the original review to be accurate and are unable to recommend any additional allowance.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.
- 3244 – The billing of the procedure code has exceeded the national correct coding initiative medically unlikely edits amount for the number of times this procedure can be billed on a date of service. An allowance has not been paid.
- 119 - Benefit maximum for this time period or occurrence has been reached.
- 163 - The charge for this procedure exceeds the unit value and/or the multiple procedure rules.

Issues

1. What are the services in dispute?
2. Are the insurance carrier's denials supported?
3. Is the requester entitled to reimbursement?

Findings

1. The requester is seeking additional reimbursement for CPT Code 97116-GP, rendered on March 12, 2025. The insurance carrier previously issued a payment of $205.54, referencing the denial reason codes listed below. The requester is now requesting an additional amount of $170.54.

   The Division of Workers' Compensation (DWC) will assess whether the carrier's payment complies with the applicable Medical Fee Guidelines, as outlined in 28 Texas Administrative Code (TAC) §134.203.

   28 TAC §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 CPT code 97116-GP defined as:

   "Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)."

   The "GP" modifier appended to the code indicates that the services were delivered under an outpatient physical therapy plan of care."

2. The requester is seeking an additional payment of $170.54 for CPT Code 97116-GP. The insurance carrier issued a partial payment and denied the remaining charges, citing the following denial reason codes:

   - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 3244 – The billing of the procedure code has exceeded the national correct coding initiative medically unlikely edits amount for the number of times this procedure can be billed on a date of service. An allowance has not been paid.
   - 119 - Benefit maximum for this time period or occurrence has been reached.
   - 163 - The charge for this procedure exceeds the unit value and/or the multiple procedure rules

   A review of the submitted medical bills and Explanation of Benefits (EOBs) reveals that CPT code 97116-GP was the only procedure billed on March 12, 2025. Therefore, the application of denial reason code 97 is not substantiated in this dispute, as there were no additional services billed that would bundle or include this procedure.

   The insurance carrier also reduced payment citing denial reason code "163". Medicare Claims Processing Manual Chapter 5, 10.3.7-effective June 6, 2016, titled *Multiple Procedure Payment Reductions for Outpatient Rehabilitation Services*, states:

   - Full payment is made for the unit or procedure with the highest Practice Expense

(PE) payment.

- For subsequent units and procedures with dates of service prior to April 1, 2013, furnished to the same patient on the same day:
- Full payment is made for work and malpractice.
- 80% payment is made for the PE for services submitted on professional claims (using the ASC X12 837 professional claim format or CMS-1500 paper claim form).
- 75% payment is made for the PE for services submitted on institutional claims (using the ASC X12 837 institutional claim format or Form CMS-1450).
- 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.
- 50% payment is made for the PE for services submitted on either professional or institutional claims

To determine which services, receive the Multiple Procedure Payment Reduction (MPPR), contractors rank services based on the applicable PE relative value units (RVUs). The service with the highest PE RVU is paid at 100%, and the appropriate MPPR is applied to the remaining services. If multiple services have the highest PE RVU, contractors further rank those services by the highest total fee schedule amount and pay that service at 100%, applying MPPR to the others.

A review of Medicare policies confirms that MPPR applies to the Practice Expense component of certain time-based physical therapy codes when multiple units or procedures are provided to the same patient on the same day. Medicare publishes the list of codes subject to MPPR annually. For 2025, the codes subject to MPPR are listed in CMS-1784-F, the CY 2025 PFS Final Rule Multiple Procedure Payment Reduction Files. Notably, CPT Code 97116-GP is included in this list.

Additionally, the carrier further reduced charges citing denial reason code "3244." The DWC notes that the reports also refer to a Medicare payment policy related to Medically Unlikely Edits (MUEs). Established by Medicare in 2007, MUEs set a maximum number of units of a specific service that a provider may report for a single patient on a single date of service to prevent potentially unnecessary services.

While the DWC adopts Medicare payment policies by reference under Rule §134.203, paragraph (a)(7) states that specific provisions in the Division of Workers' Compensation rules take precedence over conflicting Medicare provisions. The Medicare MUE policy conflicts directly with the Texas Labor Code §413.014, which mandates that all determinations of medical necessity be made prospectively or retrospectively through utilization review. It also conflicts with Rule §134.600, which governs preauthorization and retrospective review procedures for professional services such as those in dispute here. Consequently, the DWC finds that Labor Code §413.014 and 28 TAC §134.600 override Medicare MUEs, and thus, the

respondent's denial reasons are unsupported.

Finally, the carrier cited denial code "119." A review of medical documentation confirms that the requester obtained preauthorization from Hartford on February 27, 2025, for CPT Code 97116-GP. The preauthorization approved six sessions of gait training with a start date of February 27, 2025, and an end date of April 27, 2025. The disputed service was provided on March 12, 2025, within the approved timeframe. Therefore, the denial is not supported.

Because the insurance carrier's denial reasons lack support, the requester is entitled to reimbursement for the disputed service.

3. 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.

CPT Code	Medicare Fee Schedule (1st unit)	MPPR for subsequent units
97116	$28.89	$21.95

   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
   - Per the medical bills, the services were rendered in Fort Worth, TX; therefore, the Medicare locality is "Fort Worth."
   - The carrier code for Texas is 4412 and the locality code for Fort Worth is 28.
   - The Medicare Participating amount for CPT code 97116 at this locality is $28.89 for the first unit and $21.95 for the subsequent units.
   - Using the formula above, the DWC calculates the MAR to be $62.68 for the first unit and $47.62 for each of the five subsequent units, resulting in a total MAR amount of $300.80. The respondent paid $205.54.
   - Additional reimbursement of $95.26 is recommended for the date of service March 12, 2025.

Conclusion

Based on the evidence presented by both the requester and respondent at the time of adjudication, and upon review of applicable Texas Workers' Compensation rules and Medicare policies, the Division of Workers' Compensation finds:

The requester has established that additional reimbursement is due. As a result, the amount ordered is $95.26.

Although not all submitted evidence is discussed in detail, it was fully considered in reaching this determination.

Order

Under the 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 Hartford Insurance Co of Illinois must remit to Peak Integrated Healthcare $95.26 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August 14, 2025 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 1-800-252-7031, opción tres o correo electronico CompConnection@tdi.texas.gov.