TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Peak Integrated Healthcare

Respondent Name
Hartford Insurance Co of Illinois

MFDR Tracking Number
M4-25-2791-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
July 7, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 6, 2025	97116-GP x 6 units	$170.54	$95.26

Requestor's Position

"Carrer is not reimbursing according to the authorization our facility received."

Amount in Dispute: $170.54

Respondent's Position

"The original bills for dos 3/6/25 was received on 3/26/25 under control number 222369219 and paid $205,54 as benefit maximum for this time period or occurrence has been reached Bill processed on 4/2/25.."

Response submitted by: The Hartford

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 guidelines for the resolution of medical fee disputes.

2. 28 TAC §134.600 sets out the requirements of prior authorization.

3. 28 TAC §134.203 sets out the reimbursement guidelines for professional medical services.
4. Texas Labor Code §413.014 sets out the requirements of utilization review.

Denial Reasons

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

- 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.
- 163 – The charge for this procedure exceeds the unit value and/or the multiple procedure rules.
- 119 – Benefit maximum for this time period or occurrence has been reached.
- 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.

Issues

1. Are the carrier's reasons for reduction of payment supported?
2. What is the rule applicable to reimbursement?
3. Is the requester entitled to additional reimbursement?

Findings

1. The requester is seeking additional reimbursement of CPT code 97116 – Gait training, performed on March 6, 2025. The explanation of benefits cites a Medicare payment policy related to the Medically Unlikely Edit (MUE).

   MUEs established the maximum number of units that a provider can report for a specific service; for a single patient; on a single date of service, under typical circumstances. These edits are designed by Medicare to identify potentially medically unnecessary services.

   While the Division of Workers' Compensation (DWC) adopts Medicare payment policies by reference, Rule §134.203(a)(7) clearly states that any specific provisions within DWC rules take precedence over conflicting Medicare policies.

   The Medicare MUE payment policy conflicts directly with the Texas Labor Code §413.014, which mandates that determinations of medical necessity be conducted prospectively or retrospectively through utilization review. It also conflicts with Rule §134.600, which outlines the procedures for preauthorization and retrospective review of professional services such as those in question.

   A review of the submitted preauthorization from Hartford, dated February 27, 2025, confirms that CPT code 97116 was authorized for six sessions, effective from February 27, 2025, through April 27, 2025. The disputed service provided on March 6, 2025, falls within this authorized timeframe.

   Therefore, the DWC concludes that Texas Labor Code §413.014 and 28 TAC §134.600 override the Medicare MUE policy, and the respondent's denial based on the MUE is unsupported.

2. The applicable DWC fee guideline for physical therapy is 28 TAC §134.203 (b) (1) which requires the application of Medicare payment policies applicable to professional services.

   The applicable Medicare payment policy is found at www.cms.gov, Medicare Claims Processing Manual, Chapter 5, Section 10.7 Multiple Procedure Payment Reductions for Outpatient Rehabilitation Services. *Medicare applies a multiple procedure payment reduction (MPPR) to the practice expense (PE) payment of select therapy services. The reduction applies to the HCPCS codes contained on the list of "always therapy" services*

(see section 20), excluding A/B MAC (B)-priced, bundled and add-on codes, regardless of the type of provider or supplier that furnishes the services. Medicare applies an MPPR to the PE payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures.

3. The MPPR Rate File that contains the payments for 2025 services is available at https://www.cms.gov/Medicare/Billing/TherapyServices/index.html.

   The calculation of the Division of Workers' Compensation (DWC) Maximum Allowable Reimbursement (MAR) is based on the formula specified in §134.203 (c)(1) & (2):

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

   - MPPR rates vary by carrier and locality.
   - The services were provided in Fort Worth, Texas (Zip code 76112).
   - The carrier code for Fort Worth is 4412 and the locality code is 28.
   - The Medicare participating amount for CPT code 97116 in this locality are $28.89 for the first unit and $21.95 for each of the subsequent five units.

   Using the formula above:

   - The MAR for the first unit is $62.68.
   - The MAR for each subsequent unit is $47.62.
   - For five subsequent units, the total is $47.62 × 5 = $238.10.
   - Therefore, the total MAR for six units is $62.68 + $238.10 = $300.80.

The insurance carrier issued a payment of $205.54. Consequently, the requester is entitled to an additional payment of $95.26 ($300.80 - $205.54).

The total allowable DWC fee guideline reimbursement is $300.80. The insurance carrier paid $205.54. The remaining balance is $95.26. This amount is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has established that additional payment is due. The amount ordered is $95.26.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to additional reimbursement for the services in dispute. 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

		August 11, 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 in accordance with 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.