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
M4-25-2859-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
July 10, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 16, 2025	97116	$170.54	$47.63

Requester's Position

"Carrier is NOT REIMBURSING according to the authorization our facility received. The patient ls approved for 6 visits that consist of CPT code 97116... Peak IHC DOES NOT ACCEPT REDUCTIONS ON WORKERS COMPENSATION CLAIMS."

Amount in Dispute: $170.54

Respondent's Position

"After further review of the documentation submitted with this dispute, there is an additional amount warranted. The original bills for dos 4/16/25 was received on 4/28/25 under control number [...] and paid $205.54 as benefit maximum for this time period or occurrence has been reached. Bill processed on 5/6/25."

Response Submitted by: The Hartford

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §413.031and 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.
4. TLC §413.014 addresses preauthorization requirements, concurrent review and certification of healthcare.

Adjustment Reasons

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

- 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.
- 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.
- 193 - ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- W3 – BILL IS A RECONSIDERATION OR APPEAL.
- 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. Did the Insurance Carrier pay an additional amount for the disputed service after the request for medical fee dispute resolution (MFDR)?
2. Is the Insurance Carrier's reimbursement reduction reason(s) based on medically unlikely

edits (MUE) and benefit maximum reached, supported?

3. Is the Insurance Carrier's reimbursement reduction reason(s) based on multiple procedure payment reduction rules supported?
4. Is the Requester entitled to additional reimbursement?

Findings

1. A review of the submitted documentation finds that per the explanation of benefits (EOB) dated May 6, 2025, the insurance carrier allowed total reimbursement in the amount of $205.54 for the service in dispute.

   The request for this medical fee dispute resolution (MFDR) was received by DWC on July 10, 2025. The insurance carrier submitted a statement dated July 25, 2025, indicating that there is an additional reimbursement amount warranted after a manual review of the submitted documentation.

   After correspondence with both parties, DWC finds no evidence to support that any additional payment has been made for the disputed service as of the date of this MFDR review. Therefore, DWC finds that additional payment has not been made for the disputed service after the request for MFDR.

2. A review of the submitted EOBs finds that reimbursement for the service in dispute was reduced in part due to benefit maximum reached for this occurrence and Medically Unlikely Edits (MUE) from CMS applied to the number of units charged for CPT code 97116.

   MUE's were implemented by Medicare in 2007. MUE's set a maximum number of units for a specific service that a provider would report under most circumstances for a single patient on a single date of service. Medicare developed MUE edits to detect potentially medically unnecessary services.

   Although DWC adopts Medicare payment policies in accordance with Rule §134.203, paragraph (a)(7) of that rule states that specific provisions contained in the Division of Workers' Compensation rules shall take precedence over any conflicting provision adopted by the Medicare program.

   The Medicare MUE payment policy is in direct conflict with Texas Labor Code §413.014 which requires that all determinations of medical necessity shall be made prospectively or retrospective through utilization review; and with Rule §134.600 which sets out the procedures for preauthorization and retrospective review of professional services such as those in dispute here.

   DWC concludes that Labor Code §413.014 and 28 TAC §134.600 take precedence over Medicare MUE's; therefore, the respondent's reduction reasons based on MUE edits and benefit maximum are not supported.

3. A review of the submitted EOBs finds that reimbursement for the service in dispute was reduced in part due to Medicare multiple procedure payment reduction (MPPR) rules.

   28 TAC §134.203which applies to the reimbursement of the service in dispute states, "(a)(5) '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…

(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:

> (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

The service in dispute, CPT Code 97116, is described as Gait Training (includes stair climbing) (one or more areas, each 15 minutes). The requester appended the code with modifier -GP, which indicates that the services were delivered under an outpatient physical therapy plan of care.

Medicare Claims Processing Manual Chapter 5, revised November 22, 2021, 10.7-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 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 and 80 percent payment is made for the PE for services submitted on professional claims (any claim submitted using the ASC X12 837 professional claim format or the CMS-1500 paper claim form) and 75 percent payment is made for the PE for services submitted on institutional claims (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, and 50 percent payment is made for the PE for services submitted on either professional or institutional claims.
>
> To determine which services will receive the MPPR, contractors shall rank services according to the applicable PE relative value units (RVU) and price the service with the highest PE RVU at 100% and apply the appropriate MPPR to the remaining services.
>
> When the highest PE RVU applies to more than one of the identified services, contractors shall additionally sort and rank these services according to highest total fee schedule amount, and price the service with the highest total fee schedule amount at 100% and apply the appropriate MPPR to the remaining services."

Review of the Medicare policies finds that the multiple procedure payment reduction (MPPR) applies to certain time-based physical therapy codes when more than one unit or procedure is provided to the same patient on the same day. DWC finds that the MPPR rule applies to the disputed service, CPT code 97116.

DWC concludes that the insurance carrier's reimbursement reduction reason based on MPPR Rules is supported.

4. The requester seeks additional reimbursement for CPT Code 97116-GP x 6 units rendered on April 16, 2025.

   A review of the submitted documentation finds that on the disputed date of service the requester documented 75 minutes (5 units) of gait training therapy rendered to the patient identified on the medical bill. DWC finds that the medical record submitted supports 97116 x 5 units rendered on April 16, 2025.

   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..."

   As has been established in the findings above, the service in dispute is subject to the multiple procedure payment reduction rule. Medicare publishes a list of the codes subject to MPPR annually. The MPPR Rate File that contains the payments for 2025 services is found at https://www.cms.gov/Medicare/Billing/TherapyServices/index.html.

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

   - MPPR rates are published by carrier and locality.
   - Disputed service was rendered in zip code 76112, locality 28, Ft. Worth.
   - The disputed date of service is April 16, 2025.
   - The Medicare participating amount for CPT code 97116 in 2025 at this locality is $28.89 for the first unit, and $21.95 for each of the subsequent 4 units.
   - The 2025 DWC Conversion Factor is 70.18
   - The 2025 Medicare Conversion Factor is 32.3465
   - Using the above formula, DWC finds the MAR is $253.17 for 5 units of CPT code 97116-GP rendered on April 16, 2025.
   - The respondent paid $205.54.
   - Additional reimbursement in the amount of $47.63 is recommended.

   DWC finds that the requester is entitled to additional reimbursement in the amount of $47.63 for CPT code 97116 x 5 units rendered on April 16, 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 additional reimbursement in the amount of $47.63

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, Hartford Insurance Co. of Illinois, must remit to the Requester, Peak Integrated Healthcare, $47.63 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	Date
Ginger Ross	Ginger Ross	August 27, 2025

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.