TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name
Daniel Beltran, D.C.

Respondent Name
Starr Indemnity & Liability Co.

MFDR Tracking Number
M4-25-2903-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
July 15, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 1, 2025	97110	$525.00	$246.73

Requester's Position

Excerpt from reconsideration request dated June 5, 2025:
"The original claim was denied with the following description: 'Services not documented in patient's medical records.' Upon review, it was Identified that the prior authorization on file is specific to lumbar therapy services. The initial claim did not include diagnosis codes that accurately reflected the lumbar area, which may have contributed to the denial.

"To address this issue:

1. The CMS-1500 form has been updated with diagnosis codes that reflect the lumbar region, consistent with the approved authorization.
2. A copy of the valid authorization has been included.
3. A progress note documenting the services provided and supporting medical necessity has been attached.

"This submission is being sent as a corrected claim for reconsideration."

Amount in Dispute: $525.00

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 §133.307 sets out the procedures for Medical Fee Dispute Resolution requests.
2. 28 TAC §134.600 sets out the preauthorization guidelines for specific treatments and services.
3. 28 TAC §134.203 set out the fee guidelines for professional medical services.

Adjustment Reasons

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

- 119 & 90409 - BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED.
- 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.
- B12-3 - SERVICES NOT DOCUMENTED IN PATIENTS' MEDICAL RECORDS.
- P12 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- 247 - A PAYMENT OR DENIAL HAS ALREADY BEEN RECOMMENDED FOR THIS SERVICE.
- B13-2 - PREVIOUSLY PAID. PAYMENT FOR THIS CLAIM/SERVICE MAY HAVE BEEN PROVIDED IN A PREVIOUS PAYMENT.

Issues

1. Did the respondent submit a supplemental position statement?

2. Are the insurance carrier's reasons for denial of CPT code 97110-GP supported?

3. Is the requester entitled to reimbursement?

Findings

1. In its initial position statement dated July 23, 2025, the respondent, Gallagher Bassett, indicated it would submit a supplemental position after a review of the disputed claim. As of the date of this medical fee dispute resolution (MFDR) review the respondent has not submitted a supplemental position response.

   DWC will base this decision on information available at the time of this review.

2. A review of the submitted explanation of benefits (EOB) finds that the insurance carrier denied reimbursement for CPT code 97110-GP x 5 units with denial reasons related to benefit maximum has been reached for the disputed service and due to lack of information and/or documentation.

   CPT code 97110 is described as "Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility."

   DWC Rule 28 TAC §134.600 (p) requires that physical and occupational therapy services, including therapeutic procedures, receive preauthorization of services. A review of the submitted documentation finds a letter of preauthorization approving nine sessions of CPT code 97110 to be provided between the dates of December 9, 2024, and March 9, 2025. DWC's review of the submitted documents finds no evidence that the therapeutic services provided on the disputed date exceeded the nine sessions approved. The disputed date of service, March 1, 2025, is within the approved date range documented in the preauthorization letter submitted.

   A review of the submitted medical record finds documentation to support that the service of 5 units of CPT code 97110, as described above, were rendered on the disputed date of service within the preauthorized date range.

   DWC finds that the insurance carrier's reimbursement denial reason of CPT code 97110-GP based on lack of documentation and based on benefit maximum has been reached, is not supported.

3. The requester is seeking reimbursement in the total amount of $525.00 for 5 units of CPT code 97110-GP rendered on March 1, 2025. Because the insurance carrier's reasons for denial are not supported, DWC finds that the requester is entitled to reimbursement.

   DWC finds that 28 TAC §134.203 applies to the billing and reimbursement of the service in dispute, stating in pertinent part, "(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."

Medicare Claims Processing Manual Chapter 5 - Part B Outpatient Rehabilitation and CORF/OPT Services states in pertinent part,

> C. Counting Minutes for Timed Codes in 15 Minute Units
>
> When only one service is provided in a day, providers should not bill for services performed for less than 8 minutes. For any single timed CPT code in the same day measured in 15 minute units, providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes through and including 22 minutes. If the duration of a single modality or procedure in a day is greater than or equal to 23 minutes, through and including 37 minutes, then 2 units should be billed. Time intervals for 1 through 8 units are as follows:
>
> **Units Number of Minutes**
> 1 unit: ≥ 8 minutes through 22 minutes
> 2 units:≥ 23 minutes through 37 minutes
> 3 units:≥ 38 minutes through 52 minutes
> 4 units:≥ 53 minutes through 67 minutes
> 5 units:≥ 68 minutes through 82 minutes
> 6 units:≥ 83 minutes through 97 minutes…

A review of the medical bill submitted finds that on March 1, 2025, the requester charged for 5 units of CPT code 97110. A review of the submitted medical documentation supports that on the disputed date of service the requester provided 75 minutes (5 units) of therapeutic exercise activities.

Medicare Claims Processing Manual Chapter 5, 10.3.7-effective June 6, 2016, titled Multiple Procedure Payment Reductions (MPPR) 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 the Practice Expense (PE) of certain time-based physical therapy codes when more than one unit or procedure is provided to the same patient on the same day. Medicare publishes a list of the codes subject to MPPR annually.

DWC finds that CPT Code 97110 is subject to the MPPR policy. Therefore, the first unit of CPT code 97110 will receive full payment, and the reduced PE payment will apply to all subsequent units of any timed therapy code performed on the same date of service.

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

28 TAC §134.203, which applies to the reimbursement of the disputed services, states in pertinent part, "(c) To determine the maximum allowable reimbursement (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..."

- MPPR rates are published by carrier and locality.
- Per the medical bills, the services were rendered in zip code 78265; Medicare locality is 99, Rest of Texas.
- To determine the MAR the following formula is used:
  (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = MAR
- The 2025 DWC Conversion Factor is 70.18
- The Medicare Conversion Factor in 2025 is 32.3465

- The Medicare Participating amount for CPT code 97110 at locality 99 in 2025, is $28.00 for the first unit and $21.43 for the subsequent units.
- Using the above formula, DWC finds the MAR is $60.75 for the first unit and $185.98 for the four subsequent units. Therefore, the MAR for CPT code 97110 x 5 units rendered on the disputed date of service = $246.73.
- Reimbursement in the amount of $246.73 is recommended.

DWC finds that the requester is entitled to reimbursement in the amount of $246.73.

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 is due in the amount of $246.73.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to reimbursement for the services in dispute. It is ordered that Starr Indemnity & Liability Co. must remit to Daniel Beltran, D.C. $246.73 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature:

		October 6, 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, 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.tas.gov.