



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Peak Integrated
Healthcare

Respondent Name

Old Republic Insurance Co

MFDR Tracking Number

M4-26-0385-01

Carrier's Austin Representative

Box Number 44

DWC Date Received

October 7, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 15, 2025	97110-GP	\$377.64	\$286.39
July 15, 2025	97112-GP	\$16.96	\$0.00
Total		\$394.60	\$286.39

Requester 's Position

The requester submitted a copy of their reconsideration with the request for MFDR that states, "Bill date of service 07/15/2025 was denied again after sending reconsideration for denial reason "the attachment other documentation that was received was incomplete" We have submitted all documentation that was needed for full reimbursement and should be paid in full."

Amount in Dispute: \$394.60

Respondent's Position

"The bills in question were escalated and review completed. Our bill audit company has determined that no further payment is due."

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 \(TAC\) §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.

Denial Reasons

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

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 251-2 – The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process this claim.
- N45 – Payment based on authorized amount.
- P13-1 – Payment reduce or denied based on workers' compensation jurisdictional regulations or payment policies.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the DWC Rules are applicable to documentation?
3. Is the requester entitled to additional reimbursement?

Findings

1. The services in dispute are for physical therapy serviced rendered July 15, 2025. The insurance carrier denied stating, "...The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process this claim". Review of the submitted documentation found insufficient evidence to support this denial. The services in dispute will be reviewed per applicable fee guidelines.
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*

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.
- The services were provided in Dallas, TX.
- The carrier code for Texas is 4412 and the locality code for Dallas is 11.

The Maximum Allowable Reimbursement (MAR) fee guideline is found in DWC Rule 28 §134.203 (c)(1) & (2). 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...

(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.

$(\text{DWC Conversion Factor} \div \text{Medicare Conversion Factor}) \times \text{Medicare Payment} = \text{MAR}$

- The 2025 DWC Conversion Factor is 70.18
- The 2025 Medicare Conversion Factor is 32.3465
- The Carrier/Locality where services rendered Carrier - 04412/Locality Dallas -11
- Code 97112 highest rank first unit CMS MPPR rate \$32.27, second unit \$24.45
- Code 97110 MPPR rank applicable to all units \$22.00
- $70.18/32.3465 \times \$32.27 = \70.01
- $70.18/32.3465 \times \$24.45 = \53.05
- Total allowable for code 97112 \$123.06. Carrier paid \$123.06. No additional payment due.
- $70.18/32.3465 \times \$22.00 \times 6 \text{ units} = \286.39
- Total allowable for code 97110 is \$286.39

3. The total allowable per DWC fee guideline for code 97112 is \$123.06. The insurance carrier supports payment in that amount. No additional payment is recommended. The total allowable per DWC fee guideline for code 97110 is \$286.39. 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 requester has established payment is due.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requester is entitled to additional reimbursement for the services in dispute. It is ordered that Old Republic Insurance Co must remit to Peak Integrated Health Services \$286.39 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

November 6, 2025

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 electrónico CompConnection@tdi.texas.gov.