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

Starr Specialty Insurance Co

MFDR Tracking Number

M4-26-2398-01

Insurance Carrier's Austin Representative

BOX 19 Flahive Ogden & Latson

DWC Date Received

April 24, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
February 23, 2026	97110-GP	$376.22	$289.74
February 23, 2026	97112-GP	$16.85	$0.00
March 5, 2026	97110-GP	$376.22	$289.74
March 5, 2026	97112-GP	$16.85	$0.00
	Total	$786.14	$579.48

Requester's Position

The requester did not submit a position statement with this request for MFDR. They did submit a document titled, "Request for Reconsideration" dated March 25, 2026 and April 24, 2026 that states, "After reconsideration we were again denied payment for "diagnosis not covered", and workers compensation jurisdictional fee adjustment which is incorrect we have been approved for treatment."

Amount In Dispute: $786.14

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."

Supplemental response submitted May 13, 2026

"Our supplemental response for the above reference medical fee dispute resolution is as follows: 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 Section 413.031 and other applicable laws and rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) Section 133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC Section 134.203 sets out the fee guidelines for professional medical services.
3. 28 TAC Section 134.600 sets out the procedures for preauthorization.
4. 28 TAC Section 133.210 sets out the requirements for medical bill processing by insurance carrier.

Adjustment Reasons

The insurance carrier denied payment for the disputed services with the following reasons:

- 251 – The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim.
- P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies.
- N45 – Payment based on authorized amount.
- 167 – This (these) diagnosis(es) is (are) not covered, missing, or invalid.
- 18 – Duplicate claim/service.

Issues

1. What is DWC considering in this medical fee dispute?
2. Is the insurance carrier's denials supported?
3. What rule(s) apply to reimbursement?
4. Has DWC determined if reimbursement is due to the requester?

Findings

1. The requester is seeking additional reimbursement of $16.85 for code 97112-GP for dates of service February 23, 2026 and March 5, 2026 and full reimbursement of $376.22 for these same dates of service for code 97110-GP. The insurance carrier denied for lack of, incomplete documentation and authorized amount. These denials are addressed below.
2. The denials listed on the explanation of benefits are reviewed as follows. Regarding the denial for documentation. 28 TAC Section133.210(d) states, Any request by the insurance carrier for additional documentation to process a medical bill shall:

   (1) be in writing;

   (2) be specific to the bill or the bill's related episode of care;

   (3) describe with specificity the clinical and other information to be included in the response;

   (4) be relevant and necessary for the resolution of the bill;

   (5) be for information that is contained in or in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider;

   (6) indicate the specific reason for which the insurance carrier is requesting the information; and

   (7) include a copy of the medical bill for which the insurance carrier is requesting the additional documentation.

   The information submitted with the insurance carrier's response does not support this requirement was met. This denial will not be considered in this review.

   The codes in dispute are described as 97110 – Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility and 97112 - Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities.

The medical documentation included with this request for MFDR included a document that indicates for dates of service February 23, February 25 and March 15 the following.

- Hand bike - 15
- Wrist stretching/ROM – 35
- Finger ROM/Finger pulls -10
- Fing Spreader/Fist Make – 10
- Digital blocking – 5
- Ball Squeeze – 5
- Finger Opposition – 5
- PNF Stretches - 25
- Total time 85
- Therapy Units 6 (97110)
- Therapy Units 2 (97112)

28 TAC Section 133.210(a) states, Medical documentation includes all medical reports and records, such as evaluation reports, narrative reports, assessment reports, progress report/notes, clinical notes, hospital records and diagnostic test results.

Based on the above, this document does support the number of units submitted for codes 97110 and 97112 for the dates of service in dispute.

Regarding denial based on authorized amount. 28 Texas Administrative Code Section 134.600(p) states, in relevant part: Non-emergency health care requiring preauthorization includes:

(5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels:

(A) Level I code range for Physical Medicine and Rehabilitation, but limited to:

(i) Modalities, both supervised and constant attendance;

(ii) Therapeutic procedures, excluding work hardening and work conditioning;

Review of the submitted documentation finds a Preauthorization Determination Letter dated February 19, 2026 that approved CPT codes 97110, and 97112, with a start date of February 19, 2026 and end date of May 19, 2026 for 6 sessions. The disputed services were rendered within the preauthorized timeframes. The Division finds that disputed CPT codes 97110 and

97112 were preauthorized in accordance with 28 TAC Section 134.600 without a limit on number of units. The insurance carrier's denial reason based on authorized amount is not supported.

The requestor is therefore entitled to reimbursement for CPT codes 97110 and 97112. The calculation based on the applicable fee guideline is shown below.

3. The MAR for the disputed services is calculated per 28 TAC Section 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 procedure*

   The MPPR Rate File that contains the payments for 2026 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 Garland, Texas.
   - The carrier code for Texas is 4412 and the locality code for Garland is 11.
   - The PE for 97110 is 0.41
   - The PE for 97112 is 0.47
   - Code 97112 has the highest PE and receives full reimbursement of $32.94 for the 1st unit, the 2nd unit paid at MPPR rate of $25.08
   - Code 97110 is reimbursed at the MPPR rate for all units of $22.38

   DWC Rule 28 TAC Section 134.203(c) states in pertinent part, 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…
   (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 following formula represents the calculation of the DWC MAR at Section 134.203 (c)(1) & (2). (DWC Conversion Factor ÷ Medicare Conversion Factor) x Medicare Payment = MAR. In this instance,

- The 2026 DWC Conversion Factor 72.07
- The 2026 CMS Conversion Factor 33.4009
- 97110 – 72.07/33.4009 x $22.38 = $48.29 x 6 = $289.74
- 97112 1st unit – 72.07/33.4009 x $32.94 = $71.08
- 97112 2nd unit – 72.07/33.4009 x $25.08 = $54.12
- Total code 97112 $71.08 + $54.12 = $125.20. Carrier paid $124.57. Zero due.

4. Based on the information available at the time of this review, the requester is due $289.74 for each date of service for code 97110. The carrier's reimbursement of code 97112 was at MAR no additional payment is due. The total recommended amount is $579.48.

Conclusion

The outcome of this medical fee dispute is based on the evidence the requester and the respondent presented 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.

Order

Under Texas Labor Code Sections 413.031 and 413.019, DWC has determined the requester is entitled to reimbursement for the disputed services. It is ordered that Starr Specialty Insurance Co must remit to Peak Integrated Healthcare $579.48 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC Section 134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 21, 2026 Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC Section 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 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 this *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC Section 141.1(d).

Si prefiere hablar con una persona en español acerca de esta correspondencia, favor de llamar a 800-252-7031, opción tres o correo electronico CompConnection@tdi.texas.gov.