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

Requester Name

ChiroFX

Respondent Name

City of Austin

MFDR Tracking Number

M4-26-2558-01

Insurance Carrier's Austin Representative

BOX 19 Flahive Ogden & Latson

DWC Date Received

May 13, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
October 2, 2025	97039 GP	$100.00	$0.00
October 2, 2025	97530 GP	$170.00	$0.00
October 2, 2025	97140 59 GP	$170.00	$0.00
October 2, 2025	97750 GP	$150.00	$0.00
October 2, 2025	95831	$85.00	$0.00
October 2, 2025	0101T	$350.00	$0.00
October 7, 2025	97039 GP	$100.00	$0.00
October 7, 2025	97530 GP	$85.00	$0.00
October 7, 2025	97140 59 GP	$85.00	$0.00
October 7, 2025	97110 GP	$85.00	$0.00

October 7, 2025	97112 59 GP	$85.00	$0.00
October 7, 2025	0101T	$350.00	$0.00
October 13, 2025	97039 GP	$100.00	$0.00
October 13, 2025	97530 GP	$85.00	$0.00
October 13, 2025	97140 59 GP	$170.00	$0.00
October 13, 2025	97110 GP	$85.00	$0.00
October 13, 2025	97112 59 GP	$85.00	$0.00
October 13, 2025	0101T	$350.00	$0.00
October 17, 2025	97039 GP	$100.00	$0.00
October 17, 2025	97530 GP	$85.00	$0.00
October 17, 2025	97140 59 GP	$85.00	$0.00
October 17, 2025	97110 GP	$85.00	$0.00
October 17, 2025	97112 59 GP	$85.00	$0.00
October 17, 2025	97012 GP	$65.00	$0.00
October 17, 2025	0101T	$350.00	$0.00
October 17, 2025	97124 59 GP	$75.00	$0.00
October 21, 2025	97039 GP	$100.00	$0.00
October 21, 2025	97530 GP	$85.00	$0.00
October 21, 2025	97140 59 GP	$85.00	$0.00
October 21, 2025	97110 GP	$85.00	$0.00
October 21, 2025	97112 59 GP	$85.00	$0.00
October 21, 2025	0101T	$350.00	$0.00

October 21, 2025	97124 59 GP	$75.00	$0.00
	Total	$4,485.00	$0.00

Requester's Position

"These claims were previously administered by Sedgwick Insurance; however, responsibility has since transitioned to Athens Administrators, who are now handling the claims moving forward. We submitted a request for reconsideration on April 11, 2026 with no response."

Amount In Dispute: $4,485.00

Respondent's Position

"It remains the Carrier's position that no additional monies are owed"

Response Submitted By: Flahive, Ogden & Latson

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 133.240 sets out the procedures for payment, reduction, or denial of a medical bill.
4. TAC Section 19.2009 sets out the requirements of notification.

Adjustment Reasons

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

- 181 – Procedure code was invalid on the date of service.
- 16 – Claim/service lacks information or has submission/billing error(s).
- National Correct Coding Initiative edit – either mutually exclusive of or integral to another service performed on the same day.

- 236 – This procedure or procedure/modifier combination is not compensable with another procedure or procedure/modifier combination provided on the same day according to the NCCI edits or work comp state regs/fee schedule requirements.
- 59 – Processed based on multiple or concurrent procedure rules.
- P12 – Workers compensation jurisdictional fee schedule adjustment.
- 55 – Procedure/treatment/drug is deemed experimental/investigational by the payer.

Issues

1. What is DWC considering in this medical fee dispute?
2. Are the denials listed on the explanation of benefits supported?
3. What rule(s) are applicable to reimbursement?
4. Has DWC determined whether additional reimbursement is due?

Findings

1. The requester is seeking full reimbursement of physical therapy services rendered from October 2, 2025 through October 21, 2025 in the amount of $4,485.00. After MFDR, the respondent supports a payment in the amount of $1,188.22 on May 19, 2026. DWC will review the reduction in payment and denials of submitted codes per the applicable fee guidelines.
2. The following codes were denied in full by the insurance carrier.
    - 95831 - Muscle testing, manual (separate procedure) with report; extremity (excluding hand or trunk. The insurance carrier denied as procedure code was invalid on the date of service. (Discontinued 01/01/2020.
    - 97039 – Unlisted modality (specify type and time if constant attendance). The insurance carrier denied claim lacking information or has submission/billing errors.
    - 97750 – Physical performance test or measurement (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes. Insurance carrier denied based on NCCI edits.
    - 0101T – Extracorporeal Shock wave. Insurance carrier denied stating procedure/treatment deemed experimental/investigation by the payer.
    - 97124 – Therapeutic procedure, 1 or more areas, each 15 minutes, massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion). Insurance carrier denied based on NCCI edits.

28 TAC Section 134.203(b)(1) states, 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 definition of Medicare payment policies is found 134.203(a)(5) and states, "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.

Based on the rules shown above, the denial for disputed codes are reviewed below.

- 95831 for invalid code is upheld as this code was discontinued on 01/01/2020. Therefore, for dates of service in 2025 this code is not valid. The insurance carrier's denial is upheld. No payment is recommended.

- Code 97039 was denied for lacking information or submission/billing errors. The Medicare payment policy regarding this code states, *Reporting an unlisted code requires the submission of documentation, such as a procedure report, that describes the procedure performed, including the time, effort, and equipment necessary to provide the service, as well as the medical necessity of the procedure. Documentation should include a narrative of the service when using this unlisted code.* Review of the submitted documents found insufficient evidence to support a description of the procedure performed. The insurance carrier's denial is upheld. No payment is recommended.

- Code 97750 was denied based on NCCI edits. Review of the applicable NCCI edits found Code 97750 has an unbundle relationship with code 97530 and 97140. Review of the submitted medical bill found no modifier was used to indicate this procedure was separate and distinct from other services nor did the requester's position statement detail why this code should be paid separately. The insurance carrier's denial is upheld. No payment is recommended.

- Code 0101T was denied stating the carrier deemed this to be experimental. 28 TAC Section 133.240 (q) states, in relevant part, When denying payment due to an adverse determination under this section, the insurance carrier shall comply with the requirements of Section 19.2009 of this title ... Additionally, in any instance where the insurance carrier is questioning the medical necessity or appropriateness of the health care services, the insurance carrier shall comply with the requirements of Section 19.2010 of this title ..., including the requirement that prior to issuance of an adverse determination the insurance carrier shall afford the health care provider a reasonable opportunity to discuss the billed health care with a doctor ...

Submitted documentation does not support that the insurance carrier followed the appropriate procedures for a retrospective review denial of the disputed services outlined in Section 19.2003 (b)(31) or Section 133.240 (q).

Therefore, the insurance carrier did not appropriately raise the service is considered experimental for this dispute and this denial reason will not be considered in this review.

- Code 97124 was denied based on NCCI edits. Review of the applicable NCCI edits found Code 97750 has an unbundle relation with code 97140. Review of the submitted medical bill found the 59 modifier was used to indicate this procedure was separate and distinct from other services however, the submitted documentation and the requester's position statement offer no explanation as to why this code should be paid separately. The insurance carrier's denial is upheld. No payment is recommended.

3. The codes that remain in dispute are, 97530, 97140, 97110, 97112, 97012 and 0101T.

   The rule(s) that pertain the payment of physical therapy are found in 134.203 in the following sections.

   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 procedure*

   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 Austin, Texas.
   - The carrier code for Texas is 4412 and the locality code for Austin is 31.
   - Procedure code 97530. Has a PE of 0.62. The highest. Reimbursement $35.51
   - Procedure code 97140. Has a PE of 0.4. Not the highest, MPPR rate $20.97
   - Procedure code 97110. Has a PE of 0.43. Not the highest, MPPR rate $22.13
   - Procedure code 97112. Has a PE of 0.48. Not the highest, MPPR rate $24.59
   - Procedure code 97012. Has a PE of 0.18. Not the highest, MPPR rate $11.43

   DWC Rule 28 TAC Section 134.203 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…
(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 §134.203 (c)(1)&(2).

(DWC Conversion Factor ÷ Medicare Conversion Factor) x Medicare Payment = MAR. In this instance,

- The 2025 DWC Conversion Factor 70.18
- The 2025 CMS Conversion Factor 32.3465
- Code 97530 - 70.18/32.3465 x $35.51 = $77.04 1st unit
- Code 97530 – 70.18/32.3465 x $25.02 = $54.28 2nd unit
- Total 97530 2 units = $131.32. Carrier paid $131.32. No additional payment due.
- Code 97530 – 70.18/32.3465 x $35.51 = $77.04. Carrier paid $77.04. No additional payment due.
- Code 97140 – 70.18/32.3465 x 20.97 = $45.50 x 2 = $90.99. Carrier paid $91.00. No additional payment due.
- Code 97140 – 70.18/32.3465 x $20.97 = $45.50. Carrier paid $45.50. No additional payment due.
- Code 97110 – 70.18/32.3465 x $22.13 = $48.01. Carrier paid $48.01. No additional payment due.
- Code 97112 – 70.18/32.3465 x $24.59 = $53.35. Carrier paid $53.35. No additional payment due.
- Code 97012 – 70.18/32.3465 x 11.43 = $24.80. Carrier paid $24.80. No additional payment due.

Regarding Code 0101T – This code is not found on the MPPR rate file. 28 TAC 134.203(f) states, For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement).

Specifically, 28 TAC Section 134.1(e) states that healthcare services not provided through a workers' compensation healthcare network must be reimbursed based on:

- Division fee guidelines.

- A negotiated contract; or
- A fair and reasonable reimbursement amount under subsection

(f), when neither of the above apply. CPT Code 0101T is not covered under the Division's fee guidelines and neither party submitted documentation for a negotiated contract. Hence, the service in dispute falls to a fair and reasonable reimbursement amount as set out in 28 TAC 134.1(f). 28 TAC Section 134.1(f) defines fair and reasonable reimbursement as a rate that:

- Complies with Labor Code Section 413.011 criteria.
- Ensures similar procedures in similar circumstances receive similar reimbursement; and • It is based on nationally recognized published studies, Division medical dispute decisions, and/or valuations for comparable services.

Labor Code Section 413.011 mandates that fee guidelines be:

- Fair and reasonable,
- Promote quality care and cost control,
- Encourage timely return to work, and
- Avoid excessive payments compared to similar care for individuals with comparable standards of living.

28 TAC Section 133.307 requires the requester to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with Section 134.1 of this title (relating to Medical Reimbursement) . . . when the dispute involves health care for which the DWC has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable."

28 TAC Section 133.307 requires a position statement of the disputed issue(s) that should include:

i. the requester's reasoning for why the disputed fees should be paid or refunded,
ii. how the Labor Code and division rules, including fee guidelines, impact the disputed fee issues, and
iii. how the submitted documentation supports the requester's position for each disputed fee issue.

As previously stated, reimbursement of CPT Code 011T is determined in accordance with 28 TAC Section 134.1(f) and Texas Labor Code Section 413.011, which require that payment be based on a "fair and reasonable" standard. Because no Division fee guideline or negotiated contract applies, the disputed services must be evaluated under the statutory and regulatory criteria for fair and reasonable reimbursement. After a review of the submitted

documentation and applicable standards, DWC finds that the requested reimbursement rate of $350.00 is not supported for the following reasons.

The requester did not provide documentation demonstrating that the billed charges for the disputed services reflect a fair and reasonable reimbursement rate as required under 28 TAC Section 134.1 and Labor Code Section 413.011. A health care provider's "usual and customary" charges, standing alone, do not constitute evidence of a fair and reasonable reimbursement rate. Such charges do not establish what insurers customarily pay for the same or similar services in comparable circumstances. Permitting reimbursement based solely on the provider's billed charges would effectively place payment determination within the provider's unilateral control. This outcome would be inconsistent with:

- The statutory objective of effective medical cost control, and
- The requirement that reimbursement does not exceed the amount paid for similar treatment of an injured individual of an equivalent standard of living, as contemplated by Labor Code Section 413.011.

Accordingly, usual and customary charges cannot be favorably considered absent additional objective data or documentation substantiating that the requested amount is fair and reasonable. The requester did not submit documentation to demonstrate how the requested reimbursement:

- Ensures the quality of medical care, and
- Achieves effective medical cost control as expressly required by Texas Labor Code Section 413.011.

The statute requires that reimbursement methodologies balance adequate provider compensation with system-wide cost containment. No evidence was provided to establish that the requested $350.00 satisfies this statutory framework.

The requester did not provide:

- Nationally recognized published studies,
- Independent fee analyses,
- Benchmarking data, or
- Documentation of values assigned to services involving similar work and resource commitments to substantiate the requested reimbursement amount.

Without objective comparative data, the Division cannot determine that the requested rate aligns with fair market values for services requiring comparable time, skill, intensity, and resources.

The requester did not establish that payment of the requested amount satisfies the requirements set forth in 28 TAC Section 134.1, which governs reimbursement when no fee guideline applies.

The documentation submitted does not demonstrate that the requested rate is reasonable within the context of the Texas workers' compensation system.

At the MFDR level, the requester bears the burden of proof to establish entitlement to reimbursement by a preponderance of the evidence. DWC finds that the requester failed to submit sufficient documentation to support that the requested xxx constitutes a fair and reasonable reimbursement under applicable statutes and rules. Because the evidentiary burden has not been met, payment cannot be recommended.

4. Review of the information available at the time of this review, DWC finds the insurance carrier made payment after MFDR. The denials listed on the explanation of benefits were upheld. The payments made on this EOB were at MAR. The code 0101T is subject to fair and reasonable reimbursement rules discussed above. However, the requester did not support their submitted $350 charge for procedure was a fair and reasonable amount. No additional payment is recommended.

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 not established that reimbursement is due.

Order

Under Texas Labor Code Sections 413.031 and 413.019, DWC has determined the requester is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		June 23, 2026
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 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.