



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

G. Peter Foox

Respondent Name

Sentry Casualty Co

MFDR Tracking Number

M4-13-1070-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

December 28, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...stating we much document the hours spent on this claim. I asked for the specific rule that requires this, but was told they don't have it but won't pay this account."

Amount in Dispute: \$462.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgement of medical fee dispute received however, no position statement submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 28, 2012	Physical Therapy	\$462.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - B12 – Services not documented in patient's medical records.
 - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
 - CV: CPT code submitted is based on service time and documentation does not support the time spent on this procedure.

Issues

- Did the documentation submitted by requestor support disputed services?
- Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed services as, B12 – “Services not documented in patient’s medical records.” 28 Texas Labor Code §134.203 states 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; ... and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules. Review of the submitted documentation finds that the requestor performed an office visit for the evaluation and management of an established patient and physical therapy services. The American Medical Association (AMA) CPT code descriptions for disputed services is: Procedure code 97112 GP - 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
 Procedure code 97032 GP - Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes
 Procedure code 97140 GP - Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
 Procedure code 97110 GP - Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
 Procedure code 97112 GP - 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
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 Procedure code 97110 GP - Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
 The division concludes that the documentation does not sufficiently support the level of service billed as each disputed code must document “15 minutes” of therapy, procedure or application of modality. The carrier’s denial is supported.
2. No payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

		May 14, 2014
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 in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.