



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

Medical Associates of Brownsville

Respondent Name

University of Texas System

MFDR Tracking Number

M4-14-0685-01

Carrier's Austin Representative

Box Number 46

MFDR Date Received

October 28, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please review the attached copy of Medicaid guidelines Chapter 16.2 Reimbursement; "Procedure code 97012 through 97530 may be paid in multiple quantities of each code if the claim states that multiple procedures were performed on different body areas or the claim states that physical medicine treatment was performed more than once per day."

Amount in Dispute: \$141.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...no additional recommendation is being made because the time requirements were not met based on the CMS billing guidelines for physical therapy."

Response Submitted by: Injury Management Organization, Inc

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 2, 2013	97032, 97140	\$141.00	\$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:
 - Workers Comp State Fee Schedule Adjustment
 - Charge exceeds fee schedule allowance
 - Services delivered under an OTPT physical therapy plan of care
 - Time requirements for this CPT code were not met

Issues

1. Did the requestor support billing requirements met?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed services as, "Time requirements for this CPT code were not met." 28 Texas Labor Code §134.203(b) 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..." The medical claim contains CPT codes;

- a. 97032 - Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes
- b. 97140 - Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes

Review of the submitted documentation finds "bike x 15 mins, stretching to the B LD hamstring, IT band, figure 4, SKTC 3 x 30 secs B LE, SB DKTC x 3 mins and LTR x 3 mins, manual grade 2-3 mobilization on the low back L1-L5, with STM, increase tension with c/o added pain at the L1 and L2 vertbra. Upper 5-spine and L-spine stretching with side lying and sitting with a SB left right and center 3 x 30 seconds. Core exercise, 3x 10. IFC x 15 mins with MHP to the L and T spine area." The carrier's denial is supported.

2. The requirements of 28 Texas Administrative Code §134.203(b) were not met. No additional 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

Signature

Medical Fee Dispute Resolution Officer

Date

October , 2014

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.