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
TEXAS BONE AND JOINT CENTER

Respondent Name
FEDERAL INSURANCE CO

MFDR Tracking Number
M4-14-2960-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
March 27, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our code 97001 was denied stating service partially/full furnished by another physician and procedure code inconsistent with the provider type. All of the above are false. There was no other service furnished by another physician by our group on this date of service. For this particular CPT code I will quote the CPT book's description of this code: 97001 – Physical Therapy evaluation. The notes that were included in our claim documents this."

Amount in Dispute: $22,045.60

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...on 12/11/13, the medical bill for CPT code 97001 was denied as an orthopedic doctor billed for a physical therapy evaluation when the physical therapist completed the evaluation. Pursuant to DWC Rule 133.20(e)(2), a medical bill must be submitted in the name of the licensed provider who performed the treatment. In conclusion Requestor is not owed any additional reimbursement for the dates of service at issue in this matter."

Response Submitted by: Downs Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 21, 2013 through January 8, 2014	29828, 23412, 23130, 76881, 73030, 97530, 97110, 99211, 99442, 99214, 71020, 93000, 80053, 85025, 85730, 85610, 81000 and 29807	$21,668.60	$0.00
December 11, 2013	97001	$377.00	$0.00
TOTAL		$22,045.60	$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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - B20 – Srvc partially/fully furnished by another provider
   - 8 – Procedure code inconsistent with Provider Type
   - W3 – Workers' Compensation State Fee Schedule Adjustment
   - Note: Per Rule 133.20(c)(2) a medical bill must be submitted in the name of the licensed HCP that provided the health care or that provided direct supervision of an unlicensed individual who provided the health care.

Issues

1. Did the requestor obtain payment for dates of service November 21, 2013 through January 8, 2014?
2. Did the requestor submit documentation to support that the requirements of Rule 133.20(d) were met?
3. Is the requestor entitled to reimbursement?

Findings

1. The Division contacted the requestor's contact person identified on the DWC060 , Tammy Plant on February 20, 2015 who confirmed that payment was received for the disputed charges with the exception of CPT code 97001 rendered on December 11, 2013. Requestor indicated that they continue to pursue medical fee dispute resolution for CPT code 97001 rendered on December 11, 2013. As a result, the division will render a decision on this CPT code.
2. Per 28 Texas Administrative Code §134.203 "(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; 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 requestor seeks reimbursement for CPT Code 97001 defined by the AMA CPT Code Book as "Physical therapy evaluation." Lay description "The health care provider examines the patient/client, which includes a comprehensive history, systems review, and tests and measures. Tests and measures may include, but are not limited to, range of motion, motor function, muscle performance, joint integrity, neuromuscular status, and review of orthotic or prosthetic devices. The provider formulates an assessment, prognosis, and notes an anticipated intervention."

   Review of the submitted documentation dated December 11, 2013, titled "Post-Op Evaluation" documents CPT Code 97001 and contained the following names; Daniel L. Brown, D.C., Mark Dodson, P.T., and referred by Dr. Deepak V. Chavda, M.D, as indicated in the "Subjective" section of the "Post-Op Evaluation.

   Per 28 Texas Administrative Code §133.20 "(d) The health care provider that provided the health care shall submit its own bill, unless: (1) the health care was provided as part of a return to work rehabilitation program in accordance with the Division fee guidelines in effect for the dates of service; (2) the health care was provided by an unlicensed individual under the direct supervision of a licensed health care provider, in which case the supervising health care provider shall submit the bill; (3) the health care provider contracts with an agent for purposes of medical bill processing, in which case the health care provider agent may submit the bill; or (4) the health care provider is a pharmacy that has contracted with a pharmacy processing agent for purposes of medical bill processing, in which case the pharmacy processing agent may submit the bill."

   The requestor submitted insufficient documentation to support that the conditions outlined in 28 Texas Administrative Code §133.20 were met, as a result, reimbursement cannot be recommended for CPT Code 97001.
3. Review of the submitted documentation finds that the requestor is not entitled to reimbursement for the disputed CPT Code 97001. As a result, $0.00 is 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

		April 17, 2015
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.