Texas Department of Insurance
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
PATIENT CARE INJURY CLINIC

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-20-0088-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
SEPTEMBER 12, 2019

REQUESTOR'S POSITION SUMMARY

"We submitted our bills and proper clinical documentation in a timely fashion. We feel that our facility should be paid according to the workers compensation fee schedule guidelines."

Amount in Dispute: $175.71

RESPONDENT'S POSITION SUMMARY

"After reevaluation of the CMS-1500 along with the attached documentation, CV will uphold the denial of code 97112 on each bill."

Response Submitted By: Gallagher Bassett Services

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 8, 2019 July 22, 2019 July 31, 2019	CPT Code 97112-GP	$58.57/ea X 3 = $175.71	$0.00

FINDINGS AND DECISION

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

Background

1. 28 Texas Administrative Code §133.307, effective May 31, 2012 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - B12-Service not documented in patient's medical records.

- P12-Workers' compensation jurisdictional fee schedule adjustment.
- V298-Documentation on the CMS1500 or UB04 is not supported by the information in the medical record.
- PNFC-The reimbursement is based on the CMS Physician Fee Schedule Non-Facility site of service rate.
- W3-Request for reconsideration.

Issues

Is the requestor entitled to additional reimbursement for physical therapy services rendered on July 8, July 22, and July 31, 2019?

Findings

1. Patient Care Injury Clinic PA billed for physical therapy services, CPT codes 97112-GP, 97110-GP, G0283-GP and 97140-GP, rendered on July 8, July 22, and July 31, 2019. The requestor contends that the reimbursement was not in accordance with the fee guideline and additional reimbursement of $175.71 is due for CPT code 97112-GP. CPT codes 97110, 97140 and G0283 are not in dispute.
2. According to the explanation of benefits, the respondent denied reimbursement for CPT code 97112 based upon "B12-Service not documented in patient's medical records; and V298-Documentation on the CMS1500 or UB04 is not supported by the information in the medical record."
3. The fee guidelines for disputed services is found at 28 Texas Administrative Code §134.203.
4. 28 TAC §134.203(a)(5) 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."
5. CPT code 97112 is described as "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 requestor appended the "GP" modifier to both codes. The "GP" modifier is described as "Services delivered under an outpatient physical therapy plan of care."

   A review of the submitted medical reports finds the requestor checked the boxes and noted the number of units billed for codes 97110 and 97140; however, for 97112 the box and unit were blank. The DWC finds the requestor did not support billing CPT code 97112-GP.

Conclusion

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

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		10/10/2019
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, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR 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 DWC. **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.