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
OCCUFIT-ROBERT ZUNIGA, DC

Respondent Name
TECHNOLOGY INSURANCE CO

MFDR Tracking Number
M4-20-1144-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
JANUARY 6, 2020

REQUESTOR'S POSITION SUMMARY

"Our office received EOBs from Mitchell however they were not paid correctly, according to the explanation of benefits the bill review allowance is correct however, there is a '**complex bill review reductions'**. I have already tried speaking with bill review however the just keep stating to resubmit, and say the reduction is from the reconsideration."

Disputed Amount: $779.56

RESPONDENT'S POSITION SUMMARY

"In this matter, for each date of service, Requestor billed for more units of physical therapy than the actual number of minutes documented."

Response Submitted By: Downs Stanford, PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 23, 2019 July 24, 2019 July 25, 2019 July 29, 2019 July 30, 2019 July 31, 2019	Physical Therapy Services CPT Code 97112-GP(X1)	$56.63/ea	$0.00
July 23, 2019 July 24, 2019 July 25, 2019 July 29, 2019 July 30, 2019 July 31, 2019	Physical Therapy Services CPT Code 97124-GP	$45.00/ea	$0.00
July 30, 2019	Physical Therapy Services CPT Code 97530-GP (X2)	$120.00	$0.00

July 31, 2019	Physical Therapy Services CPT Code 97110-GP (X1)	$49.78	$0.00
TOTAL		$779.56	$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 (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307, effective May 31, 2012, sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
3. The services in dispute were reduced / denied by the respondent with the following claim adjustment reason codes:
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 790-This charge was reimbursed in accordance to the Texas medical fee guideline.
   - 16-Claim/service lacks information or has submission/billing error(s).
   - 95-Plan procedures not followed.
   - U03-The billed service was reviewed by UR and authorized.
   - 205-This charge was disallowed as additional information/definition is required to clarify service/supply rendered.
   - 350-Bill has been identified as a request for reconsideration or appeal.
   - W3-In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issue

1. Does the requestor's documentation support the disputed billed charges?
2. Is the requestor entitled to reimbursement for physical therapy services?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $779.56 for physical therapy services rendered from July 23, 2019 through July 31, 2019.
2. The respondent denied reimbursement for the disputed physical therapy services based upon a lack of documentation and/or has submission/billing error(s).
3. The fee guidelines for disputed services is found at 28 TAC §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. The disputed services are described as:
   - CPT code 97110- "Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility."
   - CPT code 97530 – "Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes."
   - CPT code 97124 –" Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)."
   - CPT code 97112 –"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 all codes. The “GP” modifier is described as “Services delivered under an outpatient physical therapy plan of care.”

6. Medicare Claims Processing Manual Chapter 5, 20.2 (B), effective March 9, 2018, titled Timed and Untimed Codes, states” Several CPT codes used for therapy modalities, procedures, and tests and measurements specify that the direct (one on one) time spent in patient contact is 15 minutes. Providers report these “timed” procedure codes for services delivered on any single calendar day using CPT codes and the appropriate number of 15 minute units of service.”
7. Medicare Claims Processing Manual Chapter 5, 20.2 (C) , effective March 9, 2018, titled Counting Minutes for Timed Codes in 15 Minute Units states, “Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.3B, Documentation Requirements for Therapy Services, indicates that the amount of time for each specific intervention/modality provided to the patient is not required to be documented in the Treatment Note. However, the total number of timed minutes must be documented.”
8. A review of the submitted reports find the requestor’s documentation is missing the total time for the timed procedures to support the number of units billed. The requestor billed for 6 units per day that equals 90 minutes. A review of the submitted reports do not support 90 minutes of physical therapy; therefore, the respondent’s denial of payment due to a lack of documentation and/or has submission/billing error(s) is supported. As a result, reimbursement is not recommended.

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

Authorized Signature

		1/30/2020
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 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 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 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.