Division of Workers' Compensation

PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Peak Integrated Healthcare

Respondent Name
Wesco Insurance Co

MFDR Tracking Number
M4-24-0512-01

Carrier's Austin Representative
Box Number 17

DWC Date Received
November 1, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 21, 2023	97110-GP	$346.86	$0.00
August 21, 2023	97112-GP	$0.00	$0.00
	Total	$346.86	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a copy of their reconsideration with a handwritten note dated November 1, 2023 that states, "We disagree that the carrier does not have the information needed to process this claim for full payment."

Amount in Dispute: $346.86

Respondent's Position

"Please see the EOBs attached which shows CPT code 97110 was denied as the medical documentation lacked information, including the time the therapeutics exercises were performed. The documentation also did not indicate which exercises and body parts were exercised. The medical record specifically says, 'therapeutic exercises performed, not performed right leg, calf,

ankle and foot,' and the (redacted) the injured body part, In conclusion, Requestor did not properly document CPT code 97110, and reimbursement is not owed."

Response submitted by: Downs Stanford PC

Findings and Decision

Authority

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

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.203 sets out the billing and coding guidelines for zzzzz.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- 16 – Claim/service lacks information or has submission/billing error(s).
- 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.
- M127- Missing patient medical record for this service.
- MA30 – Missing/incomplete/invalid type of bill.
- N130 – Consult plan benefit documents/guidelines for information about restrictions for this service.
- N179 – Additional information has been requested from the member. The charges will be reconsidered upon receipt of that information.
- N45 – Payment based on authorized amount.
- P13 – Payment reduced or denied based on Workers' Compensation Jurisdictional Regulations or payment policies.
- U03 – The billed service was reviewed by UR and authorized.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal,

Issues

1. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking reimbursement of outpatient therapy billed under Code 97110 – Therapeutic procedure, 1 or more areas each 15 minutes.

   Review of the submitted encounter note indicates "Therapy Units" as 2, which is the same number of units billed for Code 97112 and reimbursed by the insurance carrier. No other therapy is documented.

   DWC Rule §134.203 (a)(5) defines "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.

   Review of the applicable CMS reporting requirements for therapy at www.cms.gov Claims Processing Manual, Section 20.2 B states in pertinent part, *For timed codes, units are reported based on the number of times the procedure is performed, as described in the HCPCS code definition.*

   A review of the medical bill finds that the requestor billed 6 units of 97110-GP, the submitted documentation does not support the billing of 6 units. The Division finds no payment is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		December 18, 2023
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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.