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
Muilenburg, Ralph T

Respondent Name
Metropolitan Transit Authority

MFDR Tracking Number
M4-16-0641-01

Carrier's Austin Representative
Box Number 29

MFDR Date Received
November 9, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Facts are that each CPT code was preauthorized under UR number 12226, enclosed and documentation supports the services. Timely filing is not an issue and does not pertain to this claim."

Amount in Dispute: $175.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier will stand on the denial of the charge made the basis of this medical fee dispute."

Response Submitted by: Pappas & Suchma, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 29, 2014	97140 -59, GP 97110 GP, -59 97530 GP, -59	$175.00	$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.

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 reimbursement guidelines for professional services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 150 – Payment adjusted because the payer deems the information submitted does not support this level of service

- 150 – Per Medicare Therapy Services for codes that are defined as per 15 minutes or each 15 minutes, must document actual amount of time spent on a cumulative basis for the modality
- B13 – Previously paid
- 29 – The time limit for filing has expired
- W3 – Additional reimbursement made on reconsideration
- 193 – Original payment decision is being maintained

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is timeliness of claim an issue?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 15 - "Per Medicare Therapy Services for codes that are defined as per 15 minutes or each 15 minutes, must document actual amount of time spent on a cumulative basis for the modality." 28 Texas Administrative 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;

   Review of Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.3B, Titled, "Documentation Requirements for Therapy Services", https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c05.pdf , 20.2 - "Reporting of Service Units With HCPCS." 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.* Insufficient evidence was found within the documents submitted with the MFDR request. The carrier's denial is supported.

2. The carrier utilized the claim adjustment code 29 – "The time limit for filing has expired". Review of the submitted documentation finds;

   a. Health claim form (1500) stamped "Request for re-consideration" with a date of 05/05/2015

   28 Texas Administrative Code §133.250 (d)) A written request for reconsideration shall:

   > (1) reference the original bill and include the same billing codes, date(s) of service, and dollar amounts as the original bill;
   >
   > (2) include a copy of the original explanation of benefits, if received, or documentation that a request for an explanation of benefits was submitted to the insurance carrier;
   >
   > (3) include any necessary and related documentation not submitted with the original medical bill to DWC support the health care provider's position; and
   >
   > (4) include a bill-specific, substantive explanation in accordance with §133.3 of this title (relating to Communication Between Health Care Providers and Insurance Carriers) that provides a rational basis to modify the previous denial or payment.

   Review of the submitted "reconsideration request" shows the modifier -25 was added to code 99212. 28 Texas Administrative Code §133.20(g) "Health care providers may correct and resubmit as a new bill an incomplete bill that has been returned by the insurance carrier." The respondent states, "It is Starr Comprehensive Solutions' position that the 05/05/2015 submission was not reconsideration as the bill had an added modifier. As a new bill the submission was more than 95 days after the date of service." The carrier's position is supported.

3. Pursuant to requirements of Rule 134.203(b) not being 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

		December , 2105
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 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 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 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.