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
ELITE HEALTHCARE OF FT. WORTH

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-16-3142-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 14, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier shall not withdraw a preauthorization or concurrent review approval once issued."

Amount in Dispute: $1,104.88

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier has paid additional monies . . . If the provider should receive the full amount it is requesting through medical dispute resolution, then the carrier requests that the provider withdraw its request for medical dispute resolution."

Response Submitted by: Flahive, Ogden & Latson, Attorneys At Law, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 19, 2014; April 1, 2015; December 15, 2015	Physical Therapy Services	$1,104.88	$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 §133.240 sets out requirements regarding medical bill payments and denials.
3. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 50 – THESE ARE NON-COVERED SERVICES BECAUSE THIS IS NOT DEEMED A 'MEDICAL NECESSITY' BY THE PAYER.
   - B1 – (B12) SERVICES NOT DOCUMENTED N PATIENT'S MEDICAL RECORDS.
   - W3 – REQUEST FOR RECONSIDERATION.
   - BL – THIS BILL IS A RECONSIDERATION OF A PREVIOUSLY REVIEWED BILL, ALLOWANCE AMOUNTS DO NOT REFLECT PREVIOUS PAYMENTS.
   - 193 – [NO DESCRIPTION OF THIS ADJUSTMENT CODE WAS FOUND WITH THE SUBMITTED MATERIALS]

Issues

1. Did the health care provider timely request medical fee dispute resolution?
2. Are there any unresolved issues of medical necessity?
3. Were the disputed services properly documented in the medical record?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states:

   > Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.
   >
   > (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

   The date of the services in dispute include November 19, 2014; April 1, 2015; and December 15, 2015. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on June 14, 2016. This date is later than one year after the date(s) of service in dispute.

   Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B).

   The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution with respect to dates of service November 19, 2014 and April 1, 2015; accordingly, these services may not be considered for review.

   However, date of service December 15, 2015 was received within the one year filing limit and is therefore timely; therefore, these services will be considered for review.

2. The insurance carrier denied disputed services with claim adjustment reason code:

   50 – "THESE ARE NON-COVERED SERVICES BECAUSE THIS IS NOT DEEMED A 'MEDICAL NECESSITY' BY THE PAYER."

   Per Texas Administrative Code §133.240(b), "the insurance carrier shall not deny reimbursement based on medical necessity for health care preauthorized or voluntarily certified under Chapter 134 of this title (relating to Benefits--Guidelines for Medical Services, Charges, and Payments)." Review of the submitted information finds documentation to support that the disputed services were preauthorized. The insurance carrier's denial reason does not meet the requirements of §133.240(b) and is not supported. As there are no unresolved issues of medical necessity, these services may be reviewed for medical fee dispute resolution.

3. Additionally, the insurance carrier denied disputed services with claim adjustment reason code:

   B1 – "(B12) SERVICES NOT DOCUMENTED N PATIENT'S MEDICAL RECORDS."

   28 Texas Administrative Code §134.203(b)(1) requires that for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply "Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers . . . and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   The services in dispute are physical therapy services, billed under CPT codes 97140-GP, 97112-GP, and 97110-GP. By definition, these services are timed codes, and per Medicare payment policy must be billed in fifteen minute increments, rounded up or down between the seventh and eighth minute, based on time spent face-to-face with the performing practitioner.

   Review of the submitted documentation finds that the medical record is insufficient to document the actual number of minutes spent with the practitioner performing each activity. The insurance carrier's denial reason is supported. No additional reimbursement 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 on 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 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	August 19, 2016
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.