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 GARLAND

Respondent Name
NEW HAMPSHIRE INSURANCE COMPANY

MFDR Tracking Number
M4-19-3716-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
April 5, 2019

## *REQUESTOR'S POSITION SUMMARY*

Requestor's Position Summary: "The attached date of service was not paid in full."

Amount in Dispute: $285.21

## *RESPONDENT'S POSITION SUMMARY*

Respondent's Position Summary: "CPT code 97140 … is billed in 15 minute increments. The actual time spend with the patient must be documented to support the multiple units billed. This time has not been supplied by the provider. This is required to support payment of the CPT code. Therefore we will uphold the down code to one unit."

Response Submitted by:

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Dispute Amount | Amount Due |
|---|---|---|---|
| November 21, 2018 to January 8, 2019 | Professional Medical Services | $285.21 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and 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 fee guideline for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - Z710 - The charge for this procedure exceeds the fee schedule allowance.
   - V340 – CPT code submitted is based on service time and documentation of time spent does not support the number of units billed. Allowance has been reduced accordingly.
   - W3 – Request for reconsideration.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - B12 – Services not documented in patient's medical records.

- P300 – The amount paid reflects a fee schedule reduction.
- 59 – Processed based on multiple or concurrent procedure rules.
- MPPT – In accordance with the CMS Physician Fee Schedule guidelines, this service was reduced due to the Physical Therapy Service rule.

**Issues**

Are the insurance carrier's reasons for denial or reduction of payment supported?

**Findings**

The insurance carrier denied disputed services with claim adjustment reason codes:

- V340 – CPT code submitted is based on service time and documentation of time spent does not support the number of units billed. Allowance has been reduced accordingly.
- B12 – Services not documented in 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."

Disputed code 97140 (manual therapy) involves hands-on manipulation techniques, including soft tissue and joint mobilization, manual traction, and/or manual lymphatic drainage. The disputed services are billed with timed codes; each unit represents a 15-minute increment. Medicare payment policies require documentation of the time spent performing each procedure, exercise or activity — either by recording the start and stop times or the total minutes for each item. Review of the submitted medical records finds insufficient documentation to support 2 units of code 97140 for each date of service. While the time for some items is documented, the total number of minutes for manual therapy services could not be identified from the notes or flow sheets. The records do not support the services as billed. The insurance carrier's denial reasons are supported. Additional payment is not 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 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

| | Grayson Richardson | May 2, 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 Rule §133.307.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.