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
ROBERT ZUNIGA, DC

Respondent Name
NEW HAMPSHIRE INSURANCE COMPANY

MFDR Tracking Number
M4-19-3720-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
April 5, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "All these dates of services do not have the same reimbursement and the reasoning is not valid."

Amount in Dispute: $374.22

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our bill audit company has determined no further payment is due."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
September 4, 2018 to September 24, 2018	Professional Medical Services	$374.22	$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:
   - 93 – No Claim level Adjustments.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - 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.
   - 59 – Processed based on multiple or concurrent procedure rules.

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:

- B12 – Services not documented in patient's medical records.

Review of the submitted Daily Therapy & Rehabilitation Notes finds insufficient documentation to support the services as billed. The disputed services are timed codes, with each unit representing a 15-minute increment. This requires documentation of the time spent performing each procedure, exercise or activity. This can be documented either by recording the start and stop times or total number of minutes for each item. While some items in the notes documented the minutes performed, the total number of minutes — even after applying the Medicare rounding rules — did not support the number of units billed.

Additionally, these services require direct contact with the health care provider; when that is required, the provider should note the direct contact or one-on-one time spent instructing, coaching or treating the patient. Further, the provider should be sure to document all required elements for each code. The daily notes presented for review failed to document sufficient information to support the services as billed. Consequently, the insurance carrier's denial reasons are supported. Additional reimbursement cannot be recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

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.