



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Elite Healthcare Fort Worth

Respondent Name

Zurich American Insurance Co

MFDR Tracking Number

M4-19-4657-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

June 25, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier is not paying according to authorization our facility received regarding this patient."

Amount in Dispute: \$55.87

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our bill audit company stands on their original review."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 13, 2018	97140	\$55.87	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment 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.

Issues

1. Is the insurance carrier’s reason for reduction of payment supported?

Findings

1. The requestor is seeking additional reimbursement in the amount of \$55.87 for date of service September 13, 2018.

The insurance carrier reduced the allowed units of Code 97140 – Manual therapy techniques, from two units to one.

Review of the submitted “Note” indicates 90 minutes of total therapy that included treadmill, lumbar stretching, core work/planks, calf/toe raise, squats, theraball, heel ball roll, one leg stands, and PNF stretches. The “Encounter” states, “Therapeutic Exercises were performed. Pelvic wedges were used with manual therapy, Manual traction was performed. Proprioceptive neuromuscular facilitation techniques performed, Co-ordination techniques were performed.”

The description of the **timed** units does not match the **narrative** of the “Encounter” notes.

The insurance carrier’s reduction is supported. No additional reimbursement is 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

Signature

Medical Fee Dispute Resolution Officer

July 26, 2019

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, effective May 31, 2012, *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. **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.