



# 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 Fort Worth

**Respondent Name**

Zurich American Insurance Co

**MFDR Tracking Number**

M4-19-4682-01

**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 5, 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:
  - P12 – Workers' compensation jurisdictional fee schedule adjustment
  - 59 – Processed based on multiple or concurrent procedure rules
  - V340 – CPT code submitted is based on service time and documentation of time spent does not support the number of units billed.

**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 5, 2018.

The insurance carrier states, “CPT 97140 – CPT code submitted is based on service time and documentation of time spent does not support the number of units billed.”

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 were performed, Co-ordination techniques were performed.”

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

The insurance carriers’ position 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 31, 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.**