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
ARCH INDEMNITY INSURANCE COMPANY

MFDR Tracking Number
M4-19-4767-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 5, 2019

Response Submitted By
Gallagher Bassett

REQUESTOR'S POSITION SUMMARY

"CARRIER IS TO PAY 80%PAYMENT FOR SERVICES FURNISHED. CARRIER ONLY PAID 75% ON THIS DATE OF SERVICE."

RESPONDENT'S POSITION SUMMARY

"The actual time spent with the patient must be documented to support the multiple units billed. This time has not been supplied by the provider therefore no additional allowance can be recommended."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
January 14, 2019	Manual Therapy 97140	$93.00	$0.00

AUTHORITY

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.
   - 59 – Processed based on multiple or concurrent procedure rules.
   - 112 – Service not furnished directly to the patient and/or not documented.

Issues

Are the insurance carrier's denial reasons supported?

Findings

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

- 112 – SERVICE NOT FURNISHED DIRECTLY TO THE PATIENT AND/OR NOT DOCUMENTED.

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."

Manual Therapy code 97140 is billed in 15-minute increments. Medicare policy requires, when billing for timed units, that the medical record must document the duration spent performing each procedure (applying Medicare's rounding rules) in order to support the services billed.

While manual traction was recorded in the therapy note, no documentation was found of the time spent performing the components of manual therapy. Medicare payment policy requires the records to document at least 8 minutes spent, directly one-on-one with the patient, performing the first unit of timed therapy; and at least 23 minutes to support a second unit. Neither minutes performed nor start/stop times were found in the therapy note or on the flowsheet. The division thus concludes the provider did not meet the requirements of Rule §134.203(b)(1).

Review of the submitted information finds the medical record does not support the services as billed. The insurance carrier's denial reason is therefore supported. Reimbursement cannot be recommended.

Conclusion

For the reasons above, the division finds the requestor failed to support that additional payment is due.
As a result, the amount ordered is $0.00.

ORDER

In accordance with Texas Labor Code §413.031, based on the information submitted for review, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	August 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.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). The division must receive the request within twenty days of your receipt of this decision.

The request may be faxed, mailed or personally delivered either to the field office handling the claim or to the division at the contact information listed on the form. You must deliver a copy of the request to all other parties involved in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** together with any other information required by 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.