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
Mitsui Sumitomo Insurance USA Inc

MFDR Tracking Number
M4-19-4789-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 8, 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: "Coventry stand by this review."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 11, 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

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 reimbursement guidelines 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
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim processed properly

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 December 11, 2018

   The insurance carrier states, "CPT 97140 is billed when the provider performs a manual therapy technique on one on more regions. This code is billed in 15 minute increments. 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."

   Review of the submitted "Note" indicates 95 minutes of total therapy that included treadmill, lumbar stretching, core work/planks, ab crunch, calf/toe raise, leg press, squats, theraball, heel ball roll, one leg stands, ball squats, 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

		July 31, 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, 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.