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
RANDY L. ATKINSON, DC

Respondent Name
ZURICH AMERICAN INSURANCE CO

MFDR Tracking Number
M4-19-1102-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
OCTOBER 29, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: Position summary not submitted.

Letter from Designated Doctor Shelley Booker, DC: "I am the designated doctor for the above claimant …**pre-authorization is not needed as any additional testing or referral required for the evaluation is not subject to preauthorization requirements nor shall those services be denied retrospectively based on medical necessity, extent of injury, or compensability…**"

Amount in Dispute: $70.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier has previously responded to this dispute on December 14, 2018. The carrier indicated that it would reprocess the medical bill and pay it pursuant to the Medical Fee Guidelines. However, we have now discussed the file with the carrier's medical bill review auditor. According to the auditor, the bill was reviewed for payment, but the code is no longer a valid Medicare CPT code. Thus, there is no fee schedule value. The carrier is following up with the provider will change the CPT code such that it is now consistent with the Medicare codes. Otherwise, the carrier's position is that the provider is not entitled to reimbursement based upon its current filings."

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 7, 2018	CPT Code 73520	$70.00	$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, effective May 31, 2012 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §127.10, effective September 1, 2012, sets out the Designated Doctor procedures and examinations.

3. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for healthcare providers professional services.
4. The services in dispute were reduced/denied by the respondent with the following claim adjustment reason code(s):
   - P2-Not a work-related injury/illness and thus not the liability of the workers' compensation carrier.
   - W3-In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. What is the applicable fee guideline?
2. Is the respondent's denial supported?
3. Is the requestor entitled to reimbursement?

Findings

1. The fee guidelines for professional services are found in 28 Texas Administrative Code §134.203.
2. According to the submitted explanation of benefits, the respondent denied reimbursement for CPT code 73520 based upon "P2-Not a work-related injury/illness and thus not the liability of the workers' compensation carrier."

   The requestor submitted a copy of a letter from Designated Doctor, Shelley Booker, that disputed service was a referral for additional testing.

   28 Texas Administrative Code §127.10(c) states, "The designated doctor shall perform additional testing when necessary to resolve the issue in question. The designated doctor shall also refer an injured employee to other health care providers when the referral is necessary to resolve the issue in question and the designated doctor is not qualified to fully resolve the issue in question. Any additional testing or referral required for the evaluation is not subject to preauthorization requirements nor shall those services be denied retrospectively based on medical necessity, extent of injury, or compensability in accordance with the Labor Code §408.027 and §413.014, Insurance Code Chapter 1305, or Chapters 10, 19, 133, or 134 of this title (relating to Workers' Compensation Health Care Networks, Agents' Licensing, General Medical Provisions, and Benefits--Guidelines for Medical Services, Charges, and Payments, respectively) but is subject to the requirements of §180.24 of this title (relating to Financial Disclosure)."

   The division finds the respondent's denial of payment for designated doctor referred testing based upon compensability is not supported per 28 Texas Administrative Code §127.10(c).
3. 28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   28 Texas Administrative Code §134.203 (b)(1) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   On the disputed date of service, the requestor billed CPT code 73520 for x-rays of hips.

   Per the AMA CPT code book, code 73520 was deleted on January 1, 2016.

   The division finds the requestor is not due reimbursement because of billing with a deleted code.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		1/11/2019
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 28 Texas Administrative Code §133.307, 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 with the Division. **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.