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
AHMED KHALIFA, MD

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-19-3926-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
APRIL 26, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The carrier has reduced this claim inappropriately and not in accordance and compliance with TDI-DWC Rule 133 and 134."

Amount in Dispute: $139.99

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier's position remains consistent with its EOB"

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 18, 2018	CPT Code 20552-50	$139.99	$0.00
	CPT Code 20553	$0.00	$0.00
TOTAL		$139.99	$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 §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following claims adjustment reason

codes:

- 97-Charge included in another charge or service.
- 899-In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient code editor) component codes of comprehensive surgery: musculoskeletal system procedure (20000-29999) has been disallowed.
- W3-Additional payment made on appeal/reconsideration.

Issues

Is the respondent's denial of payment for code 20552-50 supported? Is the requestor entitled to reimbursement?

Findings

The fee guidelines for disputed services is found at 28 Texas Administrative Code §134.203.

28 Texas Administrative Code §134.203(b)(1) "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: 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."

According to the explanation of benefits, the respondent denied reimbursement for code 20552-50 based upon reason code "97-Charge included in another charge or service."

On the disputed date of service, the requestor billed CPT codes 20552-50 and 20553.

The respondent maintains the denial of payment for code 20552-50 based upon "In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient code editor) component codes of comprehensive surgery: musculoskeletal system procedure (20000-29999) has been disallowed."

Per CCI edits, CPT code 20552 is included in code 20553, and a modifier is not allowed to differentiate the service. As a result, reimbursement is not recommended.

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

Signature	Medical Fee Dispute Resolution Officer	05/22/2019 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 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.