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
ORTHOTEXAS PHYSICIANS

Respondent Name
INDEMNITY INSURANCE COMPANY OF NORTH AMERICA

MFDR Tracking Number
M4-19-4935-01

MFDR Date Received
July 22, 2019

Carrier's Austin Representative
Box Number 15

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On this date of service, claim denied stating 'services not documented in medical records.' See the attached images & supporting documentation that supports the services provided. Please reprocess claim for payment immediately."

Amount in Dispute: $86.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier's position is that the provider has been reimbursed in accordance with the Medical Fee Guidelines. The provider is not entitled to additional reimbursement."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
February 22, 2019	72100	$86.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted 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 §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 00663 – Reimbursement has been calculated according to state fee schedule guidelines
   - Z710 – The charge for this procedure exceeds the fee schedule allowance
   - P300-1 – The amount paid reflects a fee schedule reduction
   - 00201 – (B12) Services not documented in patient's medical records
   - P12 – Workers' Compensation jurisdictional fee schedule adjustment

Issues

1. Is the insurance carrier denial reason “00663, Z710, P300-1 and P12” supported?
2. Did the requestor document the x-ray performed “in house?”
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Code 72100 rendered on February 22, 2019. Review of the EOBs presented by the parties, supports that the insurance carrier did not issue payment for this service. As a result, the Division finds that the insurance carrier’s denial reasons are not supported. The Division will now consider whether the insurance carrier’s denial reason of “B12” is supported.

2. The requestor billed CPT Code 72100 rendered on February 22, 2019. The insurance carrier in the position summary states in pertinent part, “The provider is not entitled to additional reimbursement.” The EOBs submitted for review contain denial reason code “B12” as the reason for denial of CPT Code 72100.

   The requestor billed CPT Code 72100 without a modifier, which indicates that the requestor rendered both the technical (TC) and professional (26) component of the disputed service . Review of the medical documentation dated February 22, 2019 titled “Physical Exam” indicates that an “Xray Interpretation of Lumbar Spine” was performed “In house.” However, the requestor did not include a copy of the interpretation of the x-ray of the lumbar spine.

   The Division finds that the requestor submitted insufficient documentation to support the billing of CPT Code 72100. As a result, reimbursement cannot be recommended for the CPT Code 72100 rendered on February 22, 2019.

3. Review of the submitted documentation finds that the requestor is not entitled to reimbursement for CPT Code 72100 rendered on February 22, 2019.

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 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	August 23, 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, 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. Th e request must be received by the Division within **twenty (20)** 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 MDR 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.