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
COMBINED CHIROPRACTIC SERVICES & REHABILITATION, INC.

Respondent Name
ZURICH AMERICAN INSURANCE CO

MFDR Tracking Number
M4-20-0148-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
SEPTEMBER 16, 2019

REQUESTOR'S POSITION SUMMARY

"I believe the denial for payment was addressed correctly in the initial appeal for reconsideration and the claims should be paid accordingly."

Amount in Dispute: $1,990.00

RESPONDENT'S POSITION SUMMARY

"Supplemental response will be provided once the bill auditing company has finalized their review."

Response Submitted By: Gallagher Bassett Services

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 22, 2018 December 3, 2018	CPT Code 99204	$225.00/ea.	$0.00
November 14, 2018 November 15, 2018 November 19, 2018 November 20, 2018 November 28, 2018 December 3, 2018	CPT Code 97110-GP (X4)	$180.00/ea.	$0.00
	CPT Code 97140-GP (X1)	$45.00/ea.	$0.00
December 27, 2018 January 30, 2019	CPT Code 99213	$95.00/ea.	$0.00
TOTAL		$1,990.00	$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 (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307, effective May 31, 2012 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code § 133.10, effective April 1, 2014, sets out the required billing forms and formats.
3. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 146-Diagnosis was invalid for the date(s) of service reported.
   - 16-Claim/service lacks information or has submission/billing error(s).
   - 00950-This bill is a reconsideration a previously reviewed bill, allowance amounts do not reflect previous payments.
   - W3-Additional payment made on appeal/reconsideration.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Is the requestor entitled to additional reimbursement for physical therapy and professional services rendered from October 22, 2018 to January 30, 2019?

Findings

1. Combined Chiropractic Services & Rehabilitation, Inc. billed for physical therapy and professional services, CPT codes 99204, 99213, 97110 and 97140, rendered from October 22, 2018 to January 30, 2019.
2. Zurich American Insurance Co. denied reimbursement for the disputed services based upon "146-Diagnosis was invalid for the date(s) of service reported."
3. 28 Texas Administrative Code § 133.10(f)(1)(R) states, "All information submitted on required paper billing forms must be legible and completed in accordance with this section. The parenthetical information following each term in this section refers to the applicable paper medical billing form and the field number corresponding to the medical billing form. (1) The following data content or data elements are required for a complete professional or noninstitutional medical bill related to Texas workers' compensation health care: (R) diagnosis pointer (CMS-1500, field 24E) is required."

   The requestor obtained preauthorization for physical therapy services for the diagnosis: "S9782XD Crushing injury of left foot; subsequent encounter S9032XA Contusion of left foot, initial encounter S92415A Nondisplaced fracture of proximal phalanx of left great toe, initial encounter for closed fracture."

   The requestor noted in box 21 on the claims diagnosis: "S9032XA" (left foot contusion), "S20229A" (Thoracic spine contusion), "S92415A" (fracture of left great toe), "S29012A" (Thoracic strain), "S9782XA" (crushing injury of left foot), and "A93602A".

   DWC finds the denial of payment for physical therapy and professional services is supported because code "A93602A" is an invalid code.

Conclusion

For the reasons stated above, the DWC 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 DWC has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		11/07/2019
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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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 DWC. **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.