



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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

TEXAS BONE AND JOINT CENTER

Respondent Name

STARR INDEMNITY & LIABILITY CO

MFDR Tracking Number

M4-15-0193-01

Carrier's Austin Representative

Box Number 09

MFDR Date Received

SEPTEMBER 15, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Gallagher Bassett denied a part of this claim as information submitted does not support level of service billed. X-rays, EKG, and labs that were performed for preoperative prevention. Chest-X-rays are done in order to rule out any fluid in the lungs to hinder breathing during anesthesia. EKG is done to ensure patient has a constant heart rhythm to be health for surgery. Labs are required by the Anesthesiologist to be able to administer the correct dose to the patient and what to be looking for during this operation. These procedures are all necessary to provide the patient with a safe and best outcome during and after surgery."

Amount in Dispute: \$417.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 27, 2013	CPT Code 71020 Radiologic examination, chest, 2 views, frontal and lateral	\$157.00	\$0.00
	CPT Code 93000 Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report	\$93.00	\$0.00
	CPT Code 80053-QW Comprehensive metabolic panel This panel must include the following: Albumin (82040) Bilirubin, total (82247) Calcium, total (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Phosphatase, alkaline (84075) Pot	\$73.00	\$0.00
	CPT Code 85025-QW Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	\$53.00	\$0.00

	CPT Code 85730-QW Thromboplastin time, partial (PTT); plasma or whole blood	\$41.00	\$0.00
TOTAL		\$417.00	\$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 §134.203, titled *Medical Fee Guideline for Professional Services*, 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 reason codes:
 - 150-Payer deems the information submitted does not support this level of service.
 - W1-Workers compensation state fee schedule adjustment.
 - W3-Request for reconsideration.

Issues

Does the documentation submitted support billed service? Is the requestor entitled to reimbursement?

Findings

According to the explanation of benefits, the respondent denied reimbursement for the disputed services because the documentation submitted did not support level of service billed.

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."

On the disputed date of service the requestor billed CPT codes 71020, 93000, 80053, 85025, 85730, 85610-QW. 81000-QW and 99214-25.

A review of the submitted medical documentation finds that the requestor did not submit a copy of the Chest –X-ray, EKG and lab reports to support billed service. Therefore, the respondent's denial based upon reason code "150" is supported. As a result, reimbursement is not 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 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

Date

02/26/2015

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. 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 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.