



# 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**

Texas Bone Joint Center

**Respondent Name**

Arch Insurance Co

**MFDR Tracking Number**

M4-16-1682-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

February 18, 2016

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "Services were denied stating they were not furnished directly to the patient. The medical records from this date of service document that these were provided to the patient."

**Amount in Dispute:** \$567.00

### 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
May 5, 2015	76881, 73080, 99080 -73	\$567.00	\$257.76

### 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**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 11 – (112) Service not furnished directly to the patient and/or not documented

**Issues**

1. Are the insurance carrier’s reasons for denial or reduction of payment supported?
2. What is the applicable rule that pertains to reimbursement?
3. Is the requestor entitled to additional reimbursement?

**Findings**

1. The insurance carrier denied disputed services with claim adjustment reason code 11 – “(112) Service not furnished directly to the patient and/or not documented.” Review of the submitted claim finds the following services in dispute;

- 76881 - Us xtr non-vasc complete
- 73080 - X-ray exam of elbow

Review of the submitted documentation finds; Radiographic Studies dated 5/5/15, “Examination of the right elbow in two views” and Diagnostic Ultrasound dated 5/5/15, “Ultrasound was done using SonoSite M-Turbo”. Based on the above, the insurance carrier’s denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. The services in dispute are for professional medical services. 28 Texas Administrative Code 134.203 (c) states,

To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

- (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor).

The Maximum Allowable Reimbursement will be calculated as follows:

Date of Service	Submitted Code	Allowable	MAR (DWC Conversion Factor/Medicare Conversion Factor) x Allowable = TX FEE MAR
May 5, 2015	76881 RT	\$129.52	$56.2/35.7547 \times \$129.52 = \$203.58$
May 5, 2015	73080	\$34.47	$56.2/35.7547 \times \$34.47 = \$54.18$
		Total	\$257.76

3. The total allowed amount is \$257.76. The carrier previously paid \$0.00. The remaining balance of \$257.76 is due to the requestor.

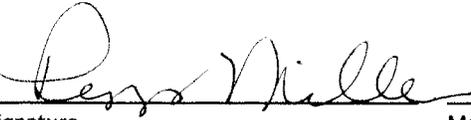
**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$257.76.

**ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$257.76 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

**Authorized Signature**

 Peggy Miller March 10, 2016  
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.**