



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

STAR ANESTHESIA

Respondent Name

ZURICH AMERICAN INSURANCE CO

MFDR Tracking Number

M4-08-3068-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

JANUARY 14, 2008

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Medicare allows these services with the procedure 00630 at a price of \$49.34 for procedure 36620. Workers' Compensation is to pay at 125% of this rate, we request that your offices send an additional \$61.54."

Amount in Dispute: \$61.54

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The current dispute involves anesthesia services provided on 10/02/07. The provider was reimbursed \$988.74 of the \$2,250.00 billed. Several items were reduced as a result of improper unbundling or fee schedule adjustments. The carrier attaches copies of its EOBs. Carrier has paid all reasonable, necessary and related charges in accordance with the applicable fee guidelines."

Respondent's Position Summary dated October 14, 2010: "Carrier maintains its position as outlined in the original response."

Responses Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 2, 2007	CPT Code 36620 Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous	\$61.54	\$61.53

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

- 28 Texas Administrative Code §134.202, effective August 1, 2003, sets the reimbursement guidelines for the disputed services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 97-Payment adjusted because the benefit for this service is included in the payment/allowance for another

service/procedure that has already been adjudicated.

- 007-36620 is incidental to procedure code 36556.
- 663-Reimbursement has been calculated according to the state fee schedule guidelines.
- 900-Based on further review, no additional allowance is warranted.
- W1-Workers compensation state fee schedule adjustment.
- W4-No additional reimbursement allowed after review of appeal/reconsideration.
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Is the allowance of CPT Code 36620 included in the allowance of another procedure performed on the disputed date of service?
2. Is the requestor entitled to reimbursement?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for CPT code 36620 based upon reason codes "97 and 007."

On the disputed date of service, the requestor billed CPT codes 00630-AA, 36556, 36620 and 99135. Per NCCI edits, CPT code 36620 is not global to any other service rendered on the disputed date.

The Division finds that the respondent did not support the denial of reimbursement for CPT code 36620; therefore, reimbursement is recommended.

2. 28 Texas Administrative Code §134.202(b) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section."

28 Texas Administrative Code §134.202(c)(1) states "To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: "for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%. For Anesthesiology services, the same conversion factor shall be used."

The Medicare allowable for CPT code 36620 in Bexar County is \$49.23. Per 28 Texas Administrative Code §134.202(c)(1) this amount is multiplied by 125% equals a MAR of \$61.53. The difference between the MAR and amount paid is \$61.53. As a result, the amount ordered is \$61.53.

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 \$61.53.

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 \$61.53 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

10/29/2014
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing 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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.