Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

STEVEN THRONTON MD
8210 WALNUT HILL LANE SUITE 130
DALLAS TX 75231

Respondent Name

ARCH INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-11-2437-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "29826 is not integral w/ 23412 & 29822. Sent AAOS global data & Medicare CCI edit and documentation."

Amount in Dispute: $3123.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts that it has paid according to applicable fee guidelines. In this case, the disputed service is included in the allowance for another service/procedure."

Response Submitted by: Flahive, Ogden & Latson, P.O. Box 13367, Austin, TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 10, 2010	CPT code 29826-51	$3123.00	$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*, set out the fee guideline s for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated December 8, 2010
   - 97-Payment is included in the allowance for another service/procedure.

Explanation of benefits dated February 4, 2011

- 97- Payment is included in the allowance for another service/procedure.

Issues

1. Did the requestor support position that CPT code 29826-51 is not integral to CPT codes 29822-59 and 23412? Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.203(b)(1), states "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   For the disputed date of service, the requestor billed CPT codes 23412, 29822-59, 29826-51 and L3675. The respondent denied reimbursement for CPT code 29826-51 based upon reason denial code "97."

   CPT code 29826 is defined as "Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure)."

   Per NCCI edits, CPT code 29826 is a component of code 23412; however a modifier is allowed in order to differentiate between the services provided. The requestor attached modifier "51-multiple procedure" to code 29826. This modifier does not differentiate between the services provided; therefore, reimbursement cannot be 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	3/20/2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it 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.