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
Ascendant Anesthesia

Respondent Name
Property & Casualty INS Co

MFDR Tracking Number
M4-14-0382-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
September 30, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…They did not pay Code 64415 59 or 76942 26 stating "services not documented in patient's record." That denial is incorrect. We provided the necessary documentation to the carrier for both of these codes billed."

Amount in Dispute: $197.87

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgement of medical fee dispute received however, no position statement submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 26, 2013	64415, 76942	$197.87	$197.87

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 sets out the reimbursement guidelines for professional medical services.
3. 28 Texas Administrative Code §133.210 defines medical documentation.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 193 – Original payment decision maintained
   - B12 – Svcs not documented in patient record

Issues

1. Did the requestor support services as billed with medical documentation?
2. What is the applicable rule regarding fee guidelines?

3. Is the requestor entitled to reimbursement?

Findings

1. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box which was acknowledged received on October 8, 2013. The insurance carrier did not submit a response for consideration in this review. Per the Division's former rule at 28 Texas Administrative Code §133.307(d)(1), effective May 25, 2008, 33 *Texas Register* 3954, "If the Division does not receive the response information within 14 calendar days of the dispute notification, then the Division may base its decision on the available information." Accordingly, this decision is based on the available information.

2. The carrier denied the services in dispute as B12 – "Svcs not documented in patient record". 28 Texas Administrative Code §133.210(a) defines medical documentation as, "Medical documentation includes all medical reports and records, such as evaluation reports, narrative reports, assessment reports, progress report/notes, clinical notes, hospital records and diagnostic test results." Review of the submitted documentation finds;
    a. Acute Pain Management Procedure note: Ultrasound-guided, injectate: 0.5% 8ml
    b. Forest Park Medical Center Progress note: image of injection into should marked with injured workers name and date of service

    The Division finds the carrier's denial is not supported the claim will be reviewed per applicable rules and fee guidelines.
3. Per 28 Texas Administrative Code §134.203 (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…" and (c) "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 annual conversion factor). For Surgery when performed in a facility setting, the established conversion factor to be applied is (date of service annual conversion factor. The maximum allowable reimbursement (MAR) is calculated as follows;

Date of Service	CPT Code	MAR (TDI-DWC Conversion Factor / Medicare Conversion Factor) x (Non-Facility Price) = MAR
June 26, 2013	64415	(69.43 / 34.023) x 122.09 = $249.15
June 26, 2013	76942	(69.43 / 34.023) x 211.61 = $431.83
	Total	$680.98

4. The total MAR for the services is $680.98. The `carrier paid 0.00. The requestor is seeking $197.87. This amount is recommended.

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 $197.87.

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 $197.87 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	August 14, 2014 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, 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.