



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

New Hampshire Insurance Co

MFDR Tracking Number

M4-14-0919-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

November 20, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Payment for this code was denied in error. As per the Texas Department of Insurance, Division of Workers Compensation fee guidelines, this code is due to be reimbursed in addition to the anesthesia code."

Amount in Dispute: \$66.65

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier asserts that CPT 76942 is improperly unbundled from the other charges. Separate reimbursement is not owed under this CPT code."

Response Submitted by: Flahive Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 11, 2013	76942 – 26	\$66.65	\$66.65

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 §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 services in dispute were reduced/denied by the respondent with the following reason codes:
 - 243 – The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed.
 - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
 - W4 – No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. Did the requestor submit medical bill according to Division rules and guidelines?
2. What is the applicable rule pertaining to fee guidelines and reimbursement?
3. Is the requestor entitled to reimbursement?

Findings

1. 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 with any additions or exceptions in the rules. Review of the National Correct Coding Initiative edits found as www.cms.hhs.gov, no edit between the disputed CPT codes, 78942 exists between codes 01400 and 64447. The carrier's denial is not supported. Therefore, the disputed service will be reviewed per applicable rules and fee guidelines.
2. Per 134.203(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 yearly conversion factor). The Maximum Allowable Reimbursement (MAR) is as follows (DWC Conversion Factor / Medicare Conversion Factor) x Facility Price = MAR or (69.43/34.023) x 32.79 = \$66.91.
3. The total MAR for the service in dispute is \$66.91. The requestor is seeking \$66.65. 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 \$66.65

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 \$66.65 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	September , 2014 Date
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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.