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 Southlake

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-14-2941-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 19, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Code 76942 26 was billed for ultrasonic guidance for needle placement for Code 64415 59. This procedure is used in order to determine the precise placement of the needle in order to not cause error…"

Amount in Dispute: $66.65

RESPONDENT'S POSITION SUMMARY

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

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 27, 2013	64415, 76942	$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

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. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - VA12 – Payment for this charge is not recommended without a statement documenting medical necessity.

Issues

1. Did the requestor support disputed service is payable?
2. 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 May 28, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. 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." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.
2. The carrier denied the disputed service as VA12 – "Payment for this charge is not recommended without a statement documenting medical necessity." Per 28 Texas Administrative Code §134.203(b) states in pertinent part, "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;" Review of the applicable payment policies does not include such a requirement. The carrier's denial is not supported. The disputed services will be reviewed per applicable rules and fee guidelines.
3. Per 28 Texas Administrative Code §134.203(c) states in pertinent part, "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;
    - Procedure code 64415, service date December 27, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 1.48 multiplied by the geographic practice cost index (GPCI) for work of 1 is 1.48. The practice expense (PE) RVU of 0.3 multiplied by the PE GPCI of 0.979 is 0.2937. The malpractice RVU of 0.11 multiplied by the malpractice GPCI of 0.826 is 0.09086. The sum of 1.86456 is multiplied by the Division conversion factor of $69.43 for a MAR of $129.46.
    - Procedure code 76942, service date December 27, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.67 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.67. The practice expense (PE) RVU of 5.41 multiplied by the PE GPCI of 0.979 is 5.29639. The malpractice RVU of 0.05 multiplied by the malpractice GPCI of 0.826 is 0.0413. The sum of 6.00769 is multiplied by the Division conversion factor of $55.30 for a MAR of $332.23. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $150.00.
4. The total allowable reimbursement for the services in dispute is $279.46. The amount previously paid by the insurance carrier is $129.46. The requestor is seeking additional reimbursement in the amount of $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	January , 2015 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.