



# 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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

Austin Anesthesiology Grp

**Respondent Name**

Commerce & Industry Insurance Co

**MFDR Tracking Number**

M4-15-2837-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

May 4, 2015

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "We received a second denial from the carrier and they still do not have the code we billed noted correctly on the EOBR, and stated medical necessity was not established for this procedure."

**Amount in Dispute:** \$51.84

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "...it is the carrier's position that this bill was paid correctly per the Medical Fee Schedule and our Explanation of Benefits."

**Response Submitted by:** AIG, 4100 Alpha Road, Suite 700, Dallas, TX 75244

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 8, 2014	76942 -26	\$51.84	\$51.84

#### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - Workers Compensation State Fee Schedule Adjustment
  - Per clinical guidelines, the use of ultrasound is included in the value of the primary procedure

**Issues**

1. Are the insurance carrier’s reasons for denial or reduction of payment supported?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

**Findings**

1. The insurance carrier denied disputed services as, “Per clinical guidelines, the use of ultrasound is included in the value of the primary procedure.” 28 Texas Administrative Code §134.203 (b) states that “(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;” Review of the Medicare National Correct Coding Initiative Edits finds, this code is separately payable as it is not bundled or not separately reported. The insurance carrier’s denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.
2. 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). For Surgery when performed in a facility setting, the established conversion factor to be applied is (date of service yearly conversion factor). The maximum allowable reimbursement is calculated as follows;

$$\text{TDI-DWC conversion factor} / \text{Medicare conversion factor} \times \text{non-facility price} = \text{MAR or } (69.98 / 35.8228) \times 33.83 = \$66.05$$

3. The total maximum allowable reimbursement is \$66.05. The requestor is seeking \$51.84. 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 \$51.84.

***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 \$51.84 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

\_\_\_\_\_  
June , 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, 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 MFDR 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.**