TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Austin Anesthesiology Group, PLLC

Respondent Name
New Hampshire Insurance Company

MFDR Tracking Number
M4-15-3159-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 26, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CPT Code 76942 26 is allowed to be billed as 1 (one) unit per injection site for needle placement, and is a separate and billable, reimbursed code."

Amount in Dispute: $51.84

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "… the use of ultrasound is included in the value of the primary procedure and … the charge for the procedure exceeds the amount indicated in the fee schedule.

It is the Carrier's position that the 8/6/2014 left shoulder surgery was paid in accordance the fee guidelines/schedule for the billed procedure codes (64416, 01630 and 76942)."

Response Submitted by: AIG Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 6, 2014	Ultrasonic guidance for needle placement, professional component (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

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 guidelines for billing and reimbursing professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer.

- P300 – The amount paid reflects a fee schedule reduction.
- VA12 – Payment for this charge is not recommended without a statement documenting medical necessity.
- 2 – Workers' compensation jurisdictional fee schedule adjustment.
- 3 – Per clinical guidelines, the use of ultrasound is included in the value of the primary procedure.
- 4 – The charge for the procedure exceeds the amount indicated in the fee schedule.

Issues

1. Does an unresolved medical necessity issue exist for this dispute?
2. Are the insurance carrier's reasons for denial or reduction of payment supported?
3. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
4. Is the requestor entitled to additional reimbursement?

Findings

1. On the Explanation of Benefits dated September 26, 2014, the insurance carrier denied charges in part, using claims adjustment code "50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer." Review of the submitted documentation finds that this denial was not maintained on the Explanation of Benefits dated February 4, 2015. Therefore, the Division concludes that this issue was resolved on reconsideration and no longer exists for this dispute.

2. The insurance carrier denied disputed services with claim adjustment reason code "3 – Per clinical guidelines, the use of ultrasound is included in the value of the primary procedure." 28 Texas Administrative Code §134.203 (b) requires that "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."

   The dispute involves CPT Code 76942-26, which is defined as the professional component of "ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation." Other codes billed with this service are 01630-QK-P2 and 64416-59. Review of Medicare policies finds that there are no CCI edits for either of these codes with the disputed code. CPT Code 76942 is an active code not subject to global rules. Therefore, the insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

3. The Medicare fee for CPT Code 76942-26 on date of service August 6, 2014 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. The Division conversion factor for this date of service is $55.75. 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 0.24 multiplied by the PE GPCI of 1.014 is 0.2434. The malpractice RVU of 0.04 multiplied by the malpractice GPCI of 0.759 is 0.03036. The sum of .94376 is multiplied by the Division conversion factor of $55.75 for a MAR of $52.61.

4. 28 Texas Administrative Code §134.203 (h) states, "When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title." The total MAR for the disputed services is $52.61. The requestor is seeking usual and customary charges of $51.84. This is the lesser amount. The insurance carrier paid $0.00 for the disputed services. Therefore, an additional reimbursement of $51.84 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

	Laurie Garnes	July 10, 2015
Signature	Medical Fee Dispute Resolution Officer	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.