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
METROPOLITAN ANESTHESIA CONSULTANTS

Respondent Name
TRAVELERS INDEMNITY CO

MFDR Tracking Number
M4-20-1570-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
FEBRUARY 20, 2020

REQUESTOR'S POSITION SUMMARY

"It has come to our attention our previous claim's submitted to Travelers Insurance have remained unpaid on the main ASA 01610. We have appealed twice w/medical documentation, verified with surgeon's office codes billed were correctly depicted and hcpc accuracy."

Amount in Dispute: $728.04

RESPONDENT'S POSITION SUMMARY

"The Provider contends they are entitled to separate reimbursement for CPT code 01610 (anesthesia for all procedures on the shoulder and axilla). The primary procedure performed was CPT code 24342 (distal reinsertion of a ruptured bicep or tendon). As the procedure was distal to, i.e. below, the elbow, the proper code for any anesthesia services rendered during this encounter was CPT code 01710 (anesthesia for app procedure on the upper arm and elbow). As the documentation did not support the code billed, and the correct code was not billed, the Provider is not entitled to reimbursement for the disputed service."

Response Submitted By: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 26, 2019	CPT Code 01610-AA	$728.04	$0.00

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 (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §133.20, effective January 29, 2009, sets out the healthcare providers billing procedures for medical bill submission.
3. 28 TAC §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
   - 128-The allowance is based on the anesthesia performed.
   - 245-The service provided was greater than that usually required for the listed procedure.
   - TR10-Please provide correct CPT codes for all services rendered.
   - W3-Additional payment made on appeal/reconsideration.

Issues

Is the requestor entitled to reimbursement for anesthesia services rendered on March 26, 2019?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $728.04 for CPT code 01610-AA rendered on March 26, 2019.
2. The respondent denied reimbursement for CPT code 01610 based upon "16," "P12," "128," "245," NS tr10." (Code description listed above)
3. The fee guidelines for disputed services are found in 28 TAC §134.203.

   28 TAC §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   28 TAC § 133.20(c) requires "A health care provider shall include correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitting medical bills."

   CPT code 01610 is described as "Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of shoulder and axilla."

   The requestor submitted a report that indicates the claimant underwent "Right distal biceps tendon repair." The procedure performed was to the claimant's right elbow. The respondent's denial is supported because the procedure was not to the shoulder and axilla.

   The DWC finds the submitted medical report does not support billing code 01610; therefore, reimbursement is not recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the DWC has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		07/21/2020
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, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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 DWC. **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.