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
RAJESH GUTTA DDS, MS

Respondent Name
TRAVELERS INDEMNITY COMPANY

MFDR Tracking Number
M4-21-1536-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
April 30, 2021

Response Submitted by:
Travelers

REQUESTOR'S POSITION SUMMARY

"The requestor did not submit a position summary for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review."

RESPONDENT'S POSITION SUMMARY

"The Carrier has reviewed the documentation and determined the Provider was properly reimbursed under the Division's fee schedule. The Provider is not entitled to additional reimbursement for the disputed services under the Division fee schedule."

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount in Dispute	Amount Due
September 16, 2020	30520 and 00190	$207.92	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code (TLC) §413.031 and applicable 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 §133.210
3. 28 TAC §13
4. 28 TAC §134.203, effective March 1, 2008, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 76 – Billing is greater than surgical service fee
   - 143 – Please submit anesthesia records and/or time units for further review
   - NDOC - The documentation that was received does not provide enough detailed information to determine the appropriateness of the billed service/procedure

- 4063 - Reimbursement is based on the physician fee schedule when a professional service was performed in the facility setting

Issue(s)

1. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Codes 30520 and 00190 rendered on September 16, 2020. The insurance carrier reduced the disputed services with reduction code(s), P12, 76, 143 ad 4063 (description provided above).

2. 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 Texas Administrative Code 134.203(b)(1) states, "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 requestor billed CPT Code 30530 defines as "Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft."

   The requestor also billed CPT Code 00190 defined as "Anesthesia for procedures on facial bones or skull; not otherwise specified." The requestor billed the disputed anesthesiology services using no modifier.

   28 Texas Administrative Code §134.203(c)(1) states, "…To determine to MAR for professional services, system participants shall apply the Medicare payment policies with minimal modification…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 $53.68…"

   To determine the MAR for CPT Code 30520, the following formula is used:

   - (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = Maximum Allowable Reimbursement (MAR).
   - The 2020 DWC Conversion Factor is 75.7.
   - The 2020 Medicare Conversion Factor is 36.0896
   - Review of Box 32 on the CMS-1500 the services were rendered in Midland, Texas; therefore, the locality will be based on the rate for "Rest of Texas".
   - Using the formula above, the MAR is $1,331.38
   - The insurance carrier paid the requestor $1,331.38, as a result $0.00 is recommended.

   To determine the MAR for CPT Code 00190, the following formula is used:

   - (Time units + Base Units) X Conversion Factor = Allowance.
   - The Division reviewed the submitted medical bill and finds the anesthesia was started at 9:44 am and ended at 11:38 am, for a total of 69 minutes.
   - Per Medicare Claims Processing Manual, Chapter 12, Physicians/Nonphysician Practitioners, Payment for Anesthesiology Services Section (50)(G) states, "Actual anesthesia time in minutes is reported on the claim. For anesthesia services furnished on or after January 1, 1994, the A/B MAC computes time units by dividing reported anesthesia time by 15 minutes. Round the time unit to one decimal place." Therefore, the requestor has supported 113/15 = 7.5.

- The base unit for CPT code 00190 is 05.
- The DWC Conversion Factor for 2020 is $60.32.
- The MAR for CPT code 01900 is: (Base Unit of 05 + Time Unit of 7.5 X $60.32 DWC conversion factor = MAR of $754.00.
- The insurance carrier previously paid $754.00. As a result, $0.00 is recommended.

3. Review of the submitted documentation finds that the insurance carrier reimbursed the requestor the MAR reimbursement for the services in dispute. As a result, $0.00 is recommended to the requestor.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional 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 Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		May 27, 2021
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 TAC §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 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 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 DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.