



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Lighthouse Anesthesia, PLLC

Respondent Name

ACE American Insurance Company

MFDR Tracking Number

M4-23-0940-01

Carrier's Austin Representative

Box Number 15

DWC Date Received

December 27, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 28, 2022	01402-AA	\$1,018.10	\$0.00
Total		\$1,018.10	\$0.00

Requestor's Position

"We sent a CORRECTED CLAIM to the carrier noting corrected and NOT A DUPLICATE. The carrier denied payment a 2nd time stating 'duplicate.' The carrier issued payment to my provider for the post operative pain block performed on this date of service, and payment is due for this anesthesia claim."

Amount in Dispute: \$1,018.10

Respondent's Position

ESIS submitted a copy of a Peer Review and a PLN11 in support of their denial reasons. As of today, DWC has not received a position summary from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

Findings and Decision

Authority

This medical fee dispute is decided according to [Texas Labor Code \(TLC\) §413.031](#) and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code ([TAC](#)) [§133.305](#) sets out the procedures for resolving medical disputes.
2. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.
3. [28 TAC §134.203](#) sets out the fee guideline for professional medical services.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- 1 - Original DCN 510442394
- 2 - This procedure on this date was previously reviewed (148)
- 3 -18 - Duplicate claim/service. {ANSI18}
- 4 - N522 - Duplicate of a claim processed, or to be processed, as a crossover claim.

Issues

1. Is the insurance carrier's denial supported?
2. Is the requestor entitled to reimbursement?

Findings

1. This dispute pertains to the non-payment of anesthesia services rendered on July 28, 2022 and billed under CPT code 01402-AA. The requestor is seeking reimbursement in the amount of \$1,018.10. Using the previously mentioned denial reduction codes, the insurance carrier audited and rejected the disputed service. The idea that this bill was a duplicate is not supported by an examination of the medical records. Consequently, the insurance carrier's reasons for denial are unsupported. The disputed service is therefore reviewed pursuant to the applicable rules and guidelines.

The fee guidelines for disputed services is found at 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 §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."

28 TAC §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..."

The requestor billed CPT code 01402-AA defined as "Anesthesia for open or surgical arthroscopic procedures on knee joint; total knee arthroplasty."

The requestor appended modifier "AA" described as "Anesthesia services performed personally by anesthesiologist."

To determine the MAR the following formula is used: (Time units + Base Units) X Conversion Factor = Allowance.

A copy of the "Crescent Medical Center Anesthesia Record" was sent in by the requestor for review. The DWC was unable to ascertain the anesthesia time spent because the anesthesia record was illegible. The time spent is necessary when calculating the reimbursement amount.

Pursuant to 28 TAC §133.307 (c) states, "Requests for MFDR must be legible and filed in the form and manner prescribed by the division."

2. The DWC finds that the requestor submitted medical documentation that was illegible, and as a result reimbursement could not be determined. The DWC concludes that because the requestor provided illegible medical records, the DWC was unable to determine the reimbursement amount for the disputed service.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

The DWC finds the requestor has not established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, the DWC has determined the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

February 9, 2024

Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in [28 TAC §141.1\(d\)](#).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electrónico CompConnection@tdi.texas.gov.