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
AARON Y. SHIRAZ, MD

Respondent Name
ARCH INSURANCE CO

MFDR Tracking Number
M4-16-0607-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
NOVEMBER 6, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Code 76942-26 was billed for ultrasonic guidance for needle placement for Code 64486-59. This procedure is used in order to determine the precise placement of the needle in order to not cause error."

Amount in Dispute: $65.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our bill audit company has determined no further payment is due…Per the code definition, imaging guidance is included and should not be reported separately."

Response Submitted By: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 31, 2015	CPT Code 76942-26	$65.80	$0.00

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 set out the fee guideline for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

Issues

Is the allowance of code 76942-26 included in the allowance of 64486-59?

Findings

1. 28 Texas Administrative Code §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."
2. 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."
3. According to the explanation of benefits, the respondent denied reimbursement for code 76942-26 based upon reason code "97."
4. On the disputed date of service, the requestor billed CPT codes 76942-26 and 64486-59.

   CPT code 76942-26 is defined as "Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation."

   CPT code 64486 is defined as "Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)."
5. Per CCI edits, CPT code 76942 is a component of CPT code 64486; however, a modifier is allowed to differentiate the service. A review of the requestor's billing finds that the requestor appended modifier "26-Professional Component" to CPT code 76942. This modifier does not differentiate code 76942 from 64486; therefore, the respondent's denial reason is supported. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division 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 Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		12/09/2015
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.