TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Lighthouse Anesthesia PLLC

Respondent Name
Ace American Insurance Co

MFDR Tracking Number
M4-24-1435-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
March 4, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 12, 2023	76942-26	$53.89	$53.89
	Total	$53.89	$53.89

Requestor's Position

"Please find attached a completed DWC Form 60 for the above listed patient and date of service. The carrier has denied payment of Code 76942 26. We provided documentation to support the billing of the code, and also NCCI edits to show all codes billed on our date of service were to be paid. Please review all documents provided to the carrier, and determine payment is due to our provider for the services rendered."

Amount in Dispute: $53.89

Respondent's Position

"Our initial response to the above referenced medical fee dispute resolution is as follows: we have escalated the bills in question for manual review to determine if additional monies are owed. We will provide a supplemental response once the bill auditing company has finalized their review.

Supplemental response submitted April 3, 2024

"Our bill audit company has determined no further payment is due. The rationale for this determination is… …76942 is included with 64447 therefore denial is correct. The submitted docs do not support that the charge should be allowed outside of guidelines."

Response submitted by: Gallagher Bassett

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §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) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203 sets out the billing and payment requirements for professional medical services.

Denial Reasons

- 00663 – Reimbursement has been calculated according to state fee schedule guidelines.
- 90137 – Payment adjusted .
- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 298 – The recommended allowance is based on the value for the professional component of the service performed.
- 4063 – Reimbursement is based on the physician fee schedule when a professional service was performed in the facility setting.
- 5385 – CV: This charge is not normally billed separately.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 90583 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Is the insurance carrier's denial supported?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of Code 76942 -26 rendered September 12, 2023, in a facility setting. The insurance carrier denied the claim at the original adjudication and reconsideration as the disputed service being included in another procedure. In the respondent's position statement they indicate, "…76942 is included with 64447 therefore denial is correct."

   Rule 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."

   Review of the applicable NCCI edits did not find an edit to indicate Code 76942 -26 is included in any of the other procedures billed for date of service September 12, 2023. The insurance carrier's denial is not supported.

2. Rule 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… For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

28 TAC §134.203 (c)(1) & (2) outlines the following formula for determining the DWC MAR.

The requestor appended modifier -26 to Code 76942, which indicates that the requestor billed the professional component, which may include technician supervision, interpretation of results, and written report.

The MAR (maximum allowable reimbursement) calculation for 2023 dates of service is DWC Conversion Factor/Medicare Conversion Factor multiplied by CMS Physician fee schedule amount for location of service.

A review of the submitted medical bill found that the disputed services were rendered in zip code 75146, Lancaster, Texas.

- Place of service 22, indicates that the disputed service was rendered in a facility.
- The Workers Compensation surgery conversion factor is 81.38.
- The Medicare conversion factor is 33.8872
- The Medicare fee amount is $30.60.
- Using the above formula the MAR is $73.49.
- Code 76942 -26 – (81.38/33.8872) x $30.60 = $73.49
- The requestor seeks $53.89. This amount is recommended.

3. Applicable 28 TAC 134.203(h) states that the total reimbursement is the lesser of the maximum allowable reimbursement (MAR) and the billed amount. The MAR is $73.49. The billed amount was $500.00. The MAR of $73.49 is the lesser amount. The requestor is seeking $53.89. This amount is recommended.

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.

DWC finds the requester has established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Ace American Insurance Co must remit to Lighthouse Anesthesia PLLC $53.89 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		April 11, 2024
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 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 electronico CompConnection@tdi.texas.gov.