



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Dallas Anesthesia Group

**Respondent Name**

Berkshire Hathaway Direct Insurance Company

**MFDR Tracking Number**

M4-24-1439-01

**Carrier's Austin Representative**

Box Number 6

**DWC Date Received**

March 4, 2024

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 26, 2023	76942-26	\$53.89	\$53.89
<b>Total</b>		\$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 did not process all codes billed for this patient/date of service. Our claim included Code 76924 26 and our original EOB did not include that code. We sent a reconsideration request to the carrier and they still did not process this code on the EOB they provided. The carrier owes the provider payment for all services rendered, and cannot just choose to not process the codes billed."

**Amount in Dispute:** \$53.89

### Respondent's Position

“Carrier has received and reviewed the above-referenced medical dispute. The carrier is of the opinion that this bill was correctly audited and paid under the Medical Fee Guidelines and that no additional reimbursement is owed to the provider.”

**Response submitted by:** Stone Loughlin Swanson

## **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 fee guideline requirements of professional medical services.

### Denial Reasons

- 329 – Pricing for this service represents 50% because of multiple or bilateral rules.
- 59 – Processed based on multiple or concurrent procedure rules.
- 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guidelines.
- P12 – Workers’ compensation jurisdictional fee schedule adjustment.
- P13 – Payment reduced or denied based on workers’ compensation jurisdictional regulations or payment policies.
- U03 – This billed service as reviewed by UR and authorized.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- 980 – The procedure code is disallowed based on CPT rules.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

### Issues

1. Is the respondent’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 – “Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) imaging supervision and interpretation.” The 26 modifier indicates, “professional component.” The insurance carrier denied the charge at reconsideration stating the procedure is disallowed based on CPT rules. DWC 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 Medicare payment policies, including NCCI coding manual and CCI edits found no restrictions on this disputed code. The insurance carrier’s denial is not supported. The disputed service will be reviewed per applicable fee guideline.

2. Rule 28 TAC §134.203(c)(1) states in pertinent part, “...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 following formula represents the calculation of the DWC MAR at §134.203 (c)(1).

$(\text{DWC Conversion Factor} \div \text{Medicare Conversion Factor}) \times \text{Medicare Payment for provider location} = \text{MAR}$

2023 conversion factors  $64.83/33.8872 \times \text{CMS Fee Schedule}; \$30.6$  (allowable for Dallas, TX) = \$58.54.

3. The total allowable DWC fee guideline reimbursement is \$58.54. 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 reimbursement is due.

## **Order**

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

### Authorized Signature

March 25, 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](http://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](mailto: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](mailto:CompConnection@tdi.texas.gov).