Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address: Richard C. Leech, D.O. P. O. Box 474 Hurst, Texas 76053	MDR Tracking No.: M4-05-3150-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Hartford Underwriters Insurance Company C/O Hartford Financial Services Rep Box # 27	Date of Injury: Employer's Name: Pavecon Ltd. Insurance Carrier's No.: YHZC 57899

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

"…The patient under went a right shoulder scope on 07/22/2004, and Dr. Leech administered the anesthesia for this surgery. Hartford reimbursed $233.35 for 13 units of anesthesia time. According to TWCC Rule 134.202 (c) (1), there is a fee guideline for the reimbursement of anesthesia. The rule indicates the formula on how to reimbursed for this service, however, Hartford did not follow this rule. The claim had been appealed with a letter stating what the reimbursement should be according to the fee guidelines. Hartford response was that no additional money was due. This claim should have been reimbursed at $45.98 per unit according to the MAR, making a total reimbursement of $597.74…"

Principle Documentation:
1. Requestor's position statement
2. TWCC 60/Table of Disputed Services
3. CMS 1500
4. Explanation of Benefits

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Respondent did not submit a response to this request for medical dispute resolution.

Principle Documentation:
1. N/A

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	Denial Code	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
07/22/04	F	01630 AA (Anesthesia for Open or Surgical Arthroscopic procedures)	1	$00.00
TOTAL DUE				$00.00

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Section 413.011(a-d) titled (Guidelines and Medical Policies), and Commission Rule 134.202 titled (Medical Fee Guideline) effective August 1, 2003, set out reimbursement guidelines.

1. CPT Code 01630-AA for date of service 07/22/04 was denied as "F—Reimbursement based on Medicare Fee schedule amount for facilities". Rule 134.202(c)(6) states, "for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assigned a relative value, which may be based on nationally recognized published relative studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments." The Carrier reimbursed the Requestor $233.35. No additional reimbursement is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.202
28 Texas Administrative Code Sec. §134.202(b) and (c) (1)

PART VII: DIVISION DECISION AND ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the Division has determined that the requestor **is not** entitled to additional reimbursement.

Ordered by:

		05/17/06
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005]. An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. The Division is not considered a party to the appeal.

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