**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 ( ) Insurance Carrier

| | |
|---|---|
| Requestors Name and Address:<br>ACE Anesthesia<br>4200 S. Hulen #425<br>Fort Worth TX 76109 | MDR Tracking No.: M4-05-4488-01<br>Claim No.:<br>Injured Employee's Name: |
| Respondent's Name and Box #:<br>FORT WORTH ISD<br>Representative Box #03 | Date of Injury:<br>Employer's Name: FORT WORTH ISD<br>Insurance Carrier's No.: 82681354797573 |

## PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documentation:

1. DWC-60
2. Letter of Reconsideration
3. CMS-1500
4. EOB's
5. Medical Records

Position Summary: Per Requestors letter of reconsideration "…To date we have not received a payment or correspondence from you regarding this claim…"

## PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documentation:

1. DWC-60 and Position statement
2. EOB

Position Summary: "…AccuMed recommended a payment of $116.70, which…is an over-payment…"

## 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) |
|---|---|---|---|---|
| 8/4/04 | F | 01991-QX-QS | 1 | $88.67 |
| TOTAL | | | | $88.67 |

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

The request for medical dispute in this case was received on 2/18/05.

**1.** The Requestor stated in their letter of reconsideration that "…To date we have not received a payment or correspondence from you regarding this claim…" The Respondent denied payment of code 01991-QX-QS with reduction code of "F – Reduction according to Medical Fee Guideline." The EOB submitted by the Respondent also states in part: "…originally reviewed this bill…and recommended an allowance of $116.70…" The Requestor was contacted on 11/1/06 and indicated that no payment has been received from the Respondent for this date of service in dispute. The Respondent did not provide convincing evidence of payment to the Requestor. Modifier "QX" indicates that the service was rendered by a CRNA with medical direction of the anesthesiologist. Payment for this service, when the modifier "QX" is used, is based on 50% of the allowable amount. Payment for this procedure is calculated as follows:

- Time units = 12 minutes / 15 = .8 units
- Base units (01991) = 3 units
- .8 units + 3 units = 3.8 units
- 3.8 units x $46.67(conversion factor) = $177.35
- $177.35 x 50% = $88.67

Therefore, reimbursement in the amount of $88.67 is due the Requestor.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION**

Texas Labor Code, Sec. §413.031
28 Texas Administrative Code Sec. 134.202 (a)(4)
28 Texas Administrative Code Sec. 134.1

**PART VII: DIVISION FINDINGS AND DECISION**

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** entitled to additional reimbursement in the amount of **$88.67** plus all accrued interest due at the time of payment to the Requestor within 30 days receipt of this Order.

**Order by:**

| Authorized Signature | James Schneider<br>Typed Name | 11/3/06<br>Date |
|---|---|---|

**PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW**

Appeals of a medical dispute resolution, findings and decisions 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.**