



MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) Health Care Provider () Insurance Carrier	
Requestor's Name and Address: Southwestern Pain Institute C/o Janet Allen P.O. Box 803311 Dallas TX 75380	MDR Tracking No.: M4-05-6183-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Box #: STATE OFFICE OF RISK MANAGEMENT Representative Box #45	Date of Injury:
	Employer's Name: STATE OF TEXAS
	Insurance Carrier's No.: 123271

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documentation:

1. DWC-60
2. Position Statement
3. CMS-1500
4. EOB's
5. Medical Records

Position Summary: "...Sent two reconsiderations to insurance company. They did not pay correct allowable after reconsiderations they still haven't paid correct allowable..."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documentation:

1. DWC-60 and position statement
2. EOB

Position Summary: "The office will maintain proper reimbursement was issued for a non-medically directed CRNA. Use of the (QZ) modifier indicates reimbursement is 80% of the MAR. Therefore the office respectfully requests the Commission deem a dispute does not exist..."

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)
9/14/04	F	00630-QZ-QX	1	\$00.00
TOTAL				\$00.00

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

The request for medical dispute in this case was received on 4/5/05

1. The Requestor stated in their position that "...They did not pay correct allowable after reconsiderations they still haven't paid correct allowable..." The Respondent made total payments of \$1,232.35 with reduction codes of "F – Fee Guideline MAR Reduction." Modifier "QZ" indicates that the service was rendered by a CRNA without medical direction of the anesthesiologist. Payment for this service, when the modifier "QZ" is used, is based on 80% of the actual charge or 80% of the allowable amount. Payment for this procedure is calculated as follows:

- Time units = 375 minutes / 15 = 25 units
- Base units (00630) = 8 units
- 25 units + 8 units = 33 units
- 33 units x \$46.67 (conversion factor) = \$1540.11
- \$1540.11 – \$308.02 (20% QZ modifier reduction) = \$1,232.09

Therefore, based upon the amount of reimbursement already paid, no additional reimbursement 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 not** entitled to additional reimbursement.

Decision by:

James Schneider

11/ 3 /06

Authorized Signature

Typed Name

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.