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: Southwestern Pain Institute P.O. Box 803311 Dallas, TX 75235	MDR Tracking No.: M4-07-0243-01 Claim No.: Injured Employee's Name:
Respondent's Name: American Home Assurance Co. Rep Box # 19	Date of Injury: Employer's Name: AMR Corp. Insurance Carrier's No.: YBUC23053

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary states in part, "…Insurance company paid incorrect allowable on claim. Sent reconsideration and no additional payment was allowed…"

Principle Documentation: 1. DWC 60 package
2. CMS 1500's
3. EOBs

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent did not submit a response.

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)
05/10/06	W4,W1	00630-QZ-Anesthesia	1	$139.08
TOTAL DUE				$139.08

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

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

1. The Requestor stated in their position that "…Insurance company paid incorrect allowable on claim…" The Respondent made a total payment of $378.96. The Respondent denied the service with "W4- No additional reimbursement allowed after review of appeal/reconsideration", "W1-WC State fee Schedule adjustment. Reimbursement according to the Texas Medical Fee Guidelines". Modifier QZ indicates the service was rendered bya CRNA without medical direction of the anesthesiologist. Payment for this service when the modifier "QZ" is used is based on 80% of the allowable amount. Payment for this service is calculated as follows:
   - Time units = 85 divided by 15 =5.67units
   - Base units (00630) = 8 units
   - 5.67 units + 8 units = 13.67 units
   - 13.67 units x $47.37 (conversion factor) = $647.39
   - $647.39 – $129.51 (20% QZ modifier reduction) = $518.04
   - $518.04 - $378.96 IC Payment = $139.08

   Therefore additional reimbursement in the amount of $139.08 is due to the Requestor.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code Sec. 413.011(a-d)
28 Texas Administrative Code Sec. §134.1
28 Texas Administrative Code Sec. §134.202

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 entitled to additional reimbursement in the amount of **$139.08**. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30-days of receipt of this Order.

Ordered by:

Authorized Signature	Typed Name	11/03/06 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.