



# Texas Department of Insurance

## Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48  
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645  
512-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

ANNA SCHUMAN, MD

**Respondent Name**

NEW HAMPSHIRE INSURANCE CO

**MFDR Tracking Number**

M4-14-3505-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

JULY 28, 2014

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "As indicated on the anesthesia report, general anesthesia (with intubation) was provided along with an interscalene block for post operative pain control. Our office is requesting reconsideration of denial charge 01630AA (\$1372.80). The charge was denied as bundled to line charge 64415 59 (\$1065.00). Per TWCC anesthesia fee reimbursement guidelines set forth by CMS, general anesthesia is the primary charge. Post operative blocks administered for post operative pain control purposes are secondary to the general anesthesia. These line charges should be billed with modifier 59 to indicate separate and distinct from the general anesthesia. Please review the attached CMS Anesthesia billing guide as supporting documents. ASA code 01630AA should be primarily reimbursed at the state conversion factor of \$55.75 for 2014 services."

**Amount in Dispute:** \$535.20

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The carrier relies upon its review and reduction of the provider's bill as reflected in the EOBs. The carrier asserts that it has paid according to applicable fee guidelines. All reductions of the disputed charges were appropriately made."

**Response Submitted By:** Flahive, Ogden & Latson

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 6, 2014	CPT Code 01630-AA (69 minutes) Anesthesia Services	\$535.20	\$535.20

#### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §134.203 set out the fee guideline for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.

2. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 97-the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
  - W3-Request for reconsideration.
  - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
  - BL-This bill is a reconsideration of a previously reviewed bill. Allowance amounts do not reflect previous payments.
  - BL-Additional allowance is not recommended as this bill was reviewed in accordance with state guidelines, usual and customary policies, or the providers PPO contract.

### **Issues**

1. Is the allowance of code 01630-AA included in the allowance of 66415-59?
2. Is the requestor entitled to reimbursement for code 01630-AA?

### **Findings**

1. 28 Texas Administrative Code §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 Texas Administrative Code 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 payment policies in effect on the date a service is provided with any additions or exceptions in the rules.”

According to the explanation of benefits, the respondent denied reimbursement for CPT code 01630-Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified” based upon reason code “97.”

The 2014 National Correct Coding Initiatives Manual, Chapter 2, states “A peripheral nerve block injection (CPT codes 64XXX)for postoperative pain management may be reported separately with an anesthesia 0XXXX code only if the mode of intraoperative anesthesia is general anesthesia, subarachnoid injection, or epidural injection, and the adequacy of the intraoperative anesthesia is not dependent on the peripheral nerve block injection.” The requestor supported general endotracheal anesthesia and interscalene block were performed.

Per CCI edits, CPT code 01630-AA is not bundled to 64415-59; therefore, reimbursement is recommended.

2. 28 Texas Administrative Code §134.203(c)(1) states, “...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 requestor billed CPT code 01630-AA defined as “Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified.”

The requestor billed the disputed anesthesiology service using the “AA” modifier that is described as “Anesthesia services performed personally by anesthesiologist.”

To determine the MAR the following formula is used: (Time units + Base Units) X Conversion Factor = Allowance.

The Division reviewed the submitted medical bill and finds the anesthesia was started at 0743 and ended at 0852, for a total of 69 minutes. Per Medicare Claims Processing Manual, Chapter 12, Physicians/Nonphysician Practitioners, Payment for Anesthesiology Services Section (50)(G) states “Actual anesthesia time in minutes is reported on the claim. For anesthesia services furnished on or after January 1, 1994, the A/B MAC computes time units by dividing reported anesthesia time by 15 minutes. Round the time unit to one decimal place.” Therefore, the requestor has supported  $69/15 = 4.6$ .

The base unit for CPT code 01630 is 5.

The DWC Conversion Factor is \$55.75.

The MAR for CPT code 01630-AA is: (Base Unit of 5 + Time Unit of 4.6 X \$55.75 DWC conversion factor = \$535.20. Previously paid by the respondent is \$0.00. The difference between the MAR and amount paid is \$535.20.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$535.20.

**ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$535.20 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

Signature	Medical Fee Dispute Resolution Officer	Date
		02/05/2015

**YOUR RIGHT TO APPEAL**

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

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