



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

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

STAR ANESTHESIA

Respondent Name

ARCH INSURANCE CO.

MFDR Tracking Number

M4-15-0709-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

APRIL 1, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "\$5.37 AMOUNT STILL DUE."

Amount in Dispute: \$5.37

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Copy of Provider's Contract with AWCA."

Response Submitted by: Aetna

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 22, 2009	CPT Code 00670-AA (362 minutes)	\$5.37	\$5.36

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

- 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.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
Explanation of Benefits dated August 19, 2004
 - 45-Charges exceed your contracted/legislated fee arrangement.

Issues

Is the requestor entitled to additional reimbursement per fee guideline?

Findings

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.”

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 00670-AA defined as “Anesthesia for extensive spine and spinal cord procedures (eg, spinal instrumentation or vascular procedures).”

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 0826 and ended at 1428, for a total of 362 minutes. Per Trailblazers Health Enterprises, LLC 2009 Anesthesia Manual “The 15-minute time interval will be divided into the total time indicated on the claim. Total time should always be accurately reported in minutes. Actual time units will be paid; no rounding will be done up to the next whole number – only round to the next tenth.” Therefore, the requestor has supported $362/15 = 24.13$, the total time is 24.1.

The base unit for CPT code 00670 is 13.

The DWC Conversion Factor is \$53.68.

The MAR for CPT code 00670-AA is: (Base Unit of 13 + Time Unit of 24.1 X \$53.68 DWC conversion factor = \$1,991.52. Previously paid by the respondent is \$1,986.16. The difference between the MAR and amount paid is \$5.36.

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 \$5.36.

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 \$5.36 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

12/19/2014

Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing 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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

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