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
Dennis E. Karasek, MD, PLLC

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-15-0877-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
November 10, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I submitted the appeal to Texas Mutual, who denied it on 2/4/14 … due to lack of information, submission errors and/or CPT/HCPCS billed incorrectly. We corrected the primary diagnosis code from 724.2 to 300.00 since according to Medicare LCD guidelines, this is an acceptable and matching diagnosis code. We also corrected the Modifiers from 'P2, QS' to 'QZ, QS and P2' and provided copies of the medical records for review. Only to have the claim denied again for the 2nd and 3rd time on 2/26/14 & 4/24/14 … due to the same reason and/or duplicate and not taking our corrected claim into consideration even though the original bill number was noted on the claim.

I resubmitted the claim again on 8/27/14 under the original control# … so the claim wouldn't deny again as a duplicate and I noted that the claim had been corrected before with the following corrections: the primary diagnosis code and modifiers and I attached copies of the anesthesia report to the medical records that we previously submitted before. And I also corrected the providers OB qualifying license# on box 17A, 24J & 33B of the HCFA claim form since I was told that it was required by one of their customer service representative when I called to get more information on the denial.

The claim was denied again for the same exact reasons as before so I submitted a request for reconsideration on 10/2/14 under the original control# … to avoid getting denied as a duplicate. I noted all the corrections made on the cover letter to avoid any other denials only to get denied again on 10/27/14 for the exact same reasons as before. As per their resolution department, we have exceeded their appeals limit and no further action on our claims will be provided."

Amount in Dispute: $800.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute of 1/9/14.

The requestor provided anesthesia services to the claimant on the date above and then billed Texas Mutual code 01992, anesthesia block in the prone position. However, the operative report states in part '…a CRNA administered anesthesia to the patient in which Propofol was used…' While the anesthesia record reflects that monitored anesthesia care was performed during which Propofol, among other anesthetics, was used, the record is silent regarding any blocks performed. For this reason Texas Mutual denied payment on the basis of incorrect coding of the billed procedure.

No payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 9, 2014	Anesthesia (01992)	$800.00	$334.51

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 §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.203 sets out the fee guidelines for billing and reimbursing professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-W1 – Workers Compensation Fee Schedule Adjustment.
   - CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
   - 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
   - 714 – Accurate coding is essential for reimbursement, CPT/HCPCS billed incorrectly. Corrections must be submitted w/I 95 days from DOS.
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 891 – No additional payment after reconsideration
   - CAC-18 – Exact duplicate claim/service

Issues

1. Is CPT Code 01992 the appropriate anesthesia code for the disputed services?
2. What is the total allowable for the disputed services?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied CPT Code 01992 based on incorrect coding and substantiates this in their position statement claiming that this code is "anesthesia block in the prone position." CPT Code 01992 is correctly defined as "Anesthesia **for** diagnostic or therapeutic nerve blocks **and injections** (when block or injection is performed by a different physician or other qualified health care professional); prone position" [emphasis added]. Review of the submitted documentation finds that the primary procedure, performed by a different health care provider, was placement of therapeutic spinal cord electrode arrays, which is accomplished via injection. Therefore, CPT Code 01992 is found to be the appropriate anesthesia code for the disputed services.
2. 28 Texas Administrative Code §134.203(b)(1) states, in pertinent part, "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; … and other payment policies in effect on the date a service is provided…" Chapter 12 of the Medicare Claims Processing Manual 140.3 (effective 1/1/13) states,

   > "For services furnished on or after January 1, 1996, the fee schedule for anesthesia services furnished by qualified nonphysician anesthetists is the least of 80 percent of:
   >
   > - The actual charge;
   > - The applicable locality anesthesia conversion factor multiplied by the sum of allowable base and time units."

   The base unit reported by Medicare for 2014 is 5. The requestor reported 38 minutes of monitored anesthesia time. Chapter 12 of the Medicare Claims Processing Manual 50(G) states, "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." 38 minutes divided by 15 minutes, rounded to one decimal place is 2.5 time units. 28 Texas Administrative Code §134.203 (c) defines the conversion factor to be used in place of the Medicare conversion factor. The Division of Workers' Compensation conversion factor for

anesthesia with dates of service 1/1/14-12/31/14, as reported by the commissioner, is $55.75.

Base units (5) added to time units (2.5) then multiplied by the conversion factor ($55.75) equals $418.13. As the services were provided by a qualified nonphysician anesthetist (CRNA), the total allowable is calculated at 80 %, which is $334.51

3. Because the insurance carrier's denial reasons were not supported, the requestor is entitled to reimbursement. The requestor is seeking reimbursement of $800.00. The total allowable is $334.51. Therefore, the recommended amount is $334.51.

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 $334.51.

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 $334.51 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	February 19, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

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.