



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

AUSTIN ANESTHESIOLOGY GROUP, PLLC

Respondent Name

PACIFIC INDEMNITY CO

MFDR Tracking Number

M4-15-2835-01

Carrier's Austin Representative

Box Number 17

MFDR Date Received

MAY 4, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In reviewing the services rendered by our provider we determined the supervision of the case was started by one MD and then Sam D Fason, MD took over and completed the case. Our claim was billed in the name of the provider that rendered the most time on the case and finished it. Our claim was billed correctly per the guidelines and the carrier owes payment for services rendered."

Amount in Dispute: \$936.60

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 28, 2014	CPT Code 01472-QX Anesthesia Services	\$468.30	\$468.30
	CPT Code 01472-QK Anesthesia Services	\$468.30	\$468.30
TOTAL		\$936.60	\$936.60

FINDINGS AND DECISION

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

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 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 insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 170-Denied when performed/billed by the provider.
 - P12-Workers' Compensation State Fee Schedule Adj.

- 59-Disting procedural service.
 - QK-Medicare direction of 2-4 anesth procedures.
 - 17-Denied when performed billed by this provider.
 - 18-Duplicate claim/service.
4. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on May 12, 2015. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Issues

1. Does the documentation support billing by the provider?
2. Is the requestor entitled to reimbursement for code 01472-QK and 01472-QX?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for the anesthesia services based upon reason code "17."

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."

Medicare Claims Processing Manual, Chapter 12, section 50 Payment for Anesthesiology Services states,

"If anesthesiologists are in a group practice, one physician member may provide the pre-anesthesia examination and evaluation while another fulfills the other criteria. Similarly, one physician member of the group may provide post-anesthesia care while another member of the group furnishes the other component parts of the anesthesia service. However, the medical record must indicate that the services were furnished by physicians and identify the physicians who furnished them." The requestor indicated in the letter requesting reconsideration of payment that both anesthesiologist involved in the case were member of Austin Anesthesiology Group; therefore, Medicare Claims Processing Manual, Chapter 12, section 50 policy applies to the disputed services.

Medicare's Anesthesia Billing Guide, published in October 2010, states that if anesthesiologists are in a group practice, and more than one physician member is providing anesthesia services "only one member of the group would bill for the entire anesthesia service." A review of the submitted medical bill finds that Dr. Sam Fason billed for the services.

Trailblazer's Health Enterprise, LLC, Anesthesia Manual, published September 2011, states "When the first anesthesiologist or the first CRNA starts an anesthesia procedure and he has to leave the patient to start another anesthesia procedure, and the procedure is then taken over by a second anesthesiologist or a second CRNA who then finishes the procedure, a claim should be submitted for the anesthesiologist or CRNA who spent the longest length of time with the patient. The amount of time reported on the Medicare claim should be the combined total time period of the procedure. Documentation should include the time spent with the patient for both the first and second anesthesiologist or CRNA."

A review of the submitted billing finds that both anesthesiologists are listed in the Anesthesia Record, as well as the CRNA. The Division finds that the billing is in accordance with Medicare's policy and the respondent's denial is not supported; therefore, reimbursement is recommended in accordance with 28 Texas Administrative Code §134.203(c)(1).

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 01472 defined as "Anesthesia for procedures on nerves, muscles, tendons, and fascia of lower leg, ankle, and foot; repair of ruptured Achilles tendon, with or without graft." The requestor

appended the modifier “QK” for the anesthesiologist services and “QX” for the CRNA services.

The “QK” modifier is described as “Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals.”

The “QX” modifier is defined as “Qualified nonphysician anesthetist with medical direction by a physician.”

Medicare Claims Processing Manual, Chapter 12, Payment for Anesthesia Services, Section 50(C) states “The Part B Contractor determines payment for the physician’s medical direction service furnished on or after January 1, 1998, on the basis of 50 percent of the allowance for the service performed by the physician alone. Medical direction occurs if the physician medically directs qualified individuals in two, three, or four concurrent cases.”

Medicare Claims Processing Manual, Chapter 12, Qualified Nonphysician Anesthetist and an Anesthesiologist in a Single Anesthesia Procedure Section 140.4.2 states “Where a single anesthesia procedure involves both a physician medical direction service and the service of the medically directed qualified nonphysician anesthetist, and the service is furnished on or after January 1, 1998, the payment amount for the service of each is 50 percent of the allowance otherwise recognized had the service been furnished by the anesthesiologist alone. The modifier to be used for current procedure identification is QX.”

To determine the MAR the following formula is used: $(\text{Time units} + \text{Base Units}) \times \text{Conversion Factor} = \text{Allowance}$.

The Division reviewed the submitted medical records and bill and finds the anesthesia was started at 1427 and ended at 1725, for a total of 178 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 $178/15 = 11.86$, the total time is 11.9.

The base unit for CPT code 01472 is 5.

The DWC Conversion Factor is \$55.75.

The MAR for CPT code 01472-QK is: $(\text{Base Unit of } 5 + \text{Time Unit of } 11.9 \times \$55.75 \text{ DWC conversion factor}) = \942.17 . The requestor used the QK modifier; therefore, $\$942.17 \times 50\% = \471.08 . The requestor is seeking a lesser amount of \$468.30; therefore, additional reimbursement of \$468.30 is recommended.

The MAR for CPT code 01472-QX is: $(\text{Base Unit of } 5 + \text{Time Unit of } 11.9 \times \$55.75 \text{ DWC conversion factor}) = \942.17 . The requestor used the QX modifier; therefore, $\$942.17 \times 50\% = \471.08 . The requestor is seeking a lesser amount of \$468.30; therefore, additional reimbursement of \$468.30 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$936.60.

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 \$936.60 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

08/14/2015

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, 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 MFDR 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.