



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

DOUGLAS FLANDERS, MD
EAST TEXAS ANESTHESIOLOGY ASSOC.

Respondent Name

ACE AMERICAN INSURANCE CO

MFDR Tracking Number

M4-15-2923-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

MAY 11, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Procedure code 29827 was denied as included with another procedure. The other procedure was 64415 which was a separate billing code as indicated by the 59 modifier. Please review the operative report and anesthesia records that support the billing or procedure code 29827 as a separate and billing procedure."

Amount in Dispute: \$1,610.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Enclosed please find an EOB and payment screen showing Respondent has properly paid for CPT code 01630 pursuant to the fee guideline amount. No additional reimbursement is owed for this procedure."

Response Submitted By: Downs Stanford, PC

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: May 22, 2014, CPT Code 01630-QK Anesthesia Services, \$1,610.00, \$0.00

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

- 1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 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.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
• 18-Duplicate claim/service.

Issues

Is the requestor entitled to additional reimbursement for code 01630-QK?

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.”

The respondent submitted an explanation of benefits and payment screen that indicates that check number 0119074608 was issued on May 28, 2015 for \$390.25 to requestor for code 01630-QK. To determine if the requestor is due additional reimbursement the Division refers to 28 Texas Administrative Code §134.203(c)(1).

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

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.”

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 0840 and ended at 1041, for a total of 121 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 $121/15 = 8.06$, the total time is 8.1.

The base unit for CPT code 01630 is 5.

The DWC Conversion Factor is \$55.75.

The MAR for CPT code 01630-QK is: (Base Unit of 5 + Time Unit of 8.1 X \$55.75 DWC conversion factor = \$730.32. The requestor used the QK modifier; therefore, $\$730.32 \times 50\% = \365.16 Previously paid by the respondent is \$390.25. Therefore, additional reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

		07/29/2015
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, 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.