



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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

ANESTHESIA ALLIANCE OF DALLAS, P.A.

Respondent Name

ACCIDENT FUND INSURANCE CO OF AMERICA

MFDR Tracking Number

M4-16-2465-01

Carrier's Austin Representative

Box Number 06

MFDR Date Received

APRIL 15, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has issued a payment for our service but not the correct allowable per the 2015 Texas Workers Compensation fee schedule."

Amount in Dispute: \$283.25

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier properly calculated reimbursement in this case and stands by the reasons for reduction of payment set forth in its Explanation of Benefits previously filed in this dispute."

Response Submitted by: Stone Loughlin & Swanson, LLP

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: December 6, 2015, Anesthesia Services CPT Code 00670-AA, \$283.25, \$281.00

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. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of
3. 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.
4. The services in dispute were reduced/denied by the respondent with the following reason code:
- 128-The allowance is based on the anesthesia service personally performed by an anesthesiologist.
- 235-The documentation doesn't support the level of service billed. Reimbursement was made for a code that is supported by the description and documentation submitted with the billing.
- 271-The fee schedule does not include a value for the procedure code billed. An allowance has been made which is based on charges for similar/comparable services.

- P12-Workers' compensation jurisdictional fee schedule adjustment.
- 1014-The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
- 193-Original payment decision is being maintained. This claim was processed properly the first time.
- W3-Additional payment made on appeal/reconsideration.

Issue

Is the requestor entitled to additional reimbursement?

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 0746 and ended at 1203, for a total of 257 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's documentation supported a total time of $257/15 = 17.13 - 17.1$.

The base unit for CPT code 00670 is 13.

The DWC Conversion Factor is \$56.2.

The MAR for CPT code 00670-AA is: (Base Unit of 13 + Time Unit of 17.1 X \$56.2 DWC conversion factor = \$1,691.62. Previously paid by the respondent is \$1,410.62. The difference between the MAR and amount paid is \$281.00.

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 \$281.00.

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 \$281.00 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

05/13/2016

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.