



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

STRATUS ANESTHESIA ASSOCIATES OF SOUTHLAKE

Respondent Name

OLD REPUBLIC INSURANCE CO

MFDR Tracking Number

M4-16-3089-01

Carrier's Austin Representative

Box Number 44

MFDR Date Received

JUNE 10, 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 2016 Texas Workers Compensation fee schedule."

Amount in Dispute: \$39.77

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Subject to further review, the carrier asserts that it has paid according to the applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: January 13, 2016, CPT Code 01830-QX (71 minutes) Anesthesia Services, \$35.68, \$28.48

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:
- BL-This bill is a reconsideration of a previously reviewed bill, allowance amounts do not reflect previous payments.

## Issues

Is the requestor entitled to additional reimbursement for code 01830-QX?

## Findings

1. According to the explanation of benefits, the respondent paid \$159.10 for CPT code 01830-QX based upon the fee schedule.
2. 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."
3. 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."
4. 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..."
5. The requestor billed the disputed anesthesiology service using the "QX" modifier that is described as "Qualified nonphysician anesthetist with medical direction by a physician."
6. 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."
7. To determine the MAR the following formula is used: (Time units + Base Units) X Conversion Factor = Allowance.
8. The Division reviewed the submitted medical bill and finds the anesthesia was started at 0733 and ended at 0824, for a total of 51 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  $51/15 = 3.4$ .
9. The base unit for CPT code 01830 is 3.
10. The DWC Conversion Factor is \$58.62.
11. Using the above formula, the MAR for CPT code 01830-QX is  $3.4 + 3 = 6.4 \times 58.62 = \$375.17 \times 50\%$  for QX = \$187.58. Previously paid by the respondent is \$159.10. The difference between the MAR and amount paid is \$28.48, this amount is recommended for additional reimbursement.

## 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 \$28.48.

**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 \$28.48 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

		07/07/2016
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.**