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
Anesthesia Alliance of Dallas

Respondent Name
Travelers Indemnity Co

MFDR Tracking Number
M4-16-3340-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
July 1, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The face sheet we received indicated the correct insurance carrier was MEDICARE. We billed this carrier and received a denial stating this service was related to the patient's workers compensation claim. We billed the correct carrier, Travelers Insurance, as soon as we learned of our error."

Amount in Dispute: $404.64

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…the Provider alleges they timely billed Medicare. Medicare informed the Provider of the workers' compensation claim on 12-28-2015, as indicated by the Medicare remittance notice of that same date. Yet the Provider did not submit a bill to the Carrier until 04-27-2015[sic], 120 days later, despite already having the billing information relevant to this claim. As such, the Provider does not qualify for timely submission under any of the exceptions of Texas Labor Code Sect. 408.0272, as the resubmission to the proper carrier was beyond the 95 days submission window. Consequently, the Carrier contends the Provider is not entitled to reimbursement as the billing was not timely submitted to the Carrier."

Response Submitted by: Travelers Insurance

SU MMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 20, 2015	01992 QZ	$404.64	$404.64

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 §133.20 sets out guidelines for submission of medical claims.

3. 28 Texas Administrative Code §134.230 sets out the reimbursement guidelines for professional medical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16 – Claim/service lacks information which is needed for adjudication
   - W3 – Additional payment made on appeal/reconsideration
   - 29 – The time limit for filing has expired

Issues

1. Was the claim submitted timely?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent states, "Yet the Provider did not submit a bill to the Carrier until 04-27-2015[sic]," in their position statement. Review of the submitted documentation finds;

   - Explanation of benefits from Medicare dated December 28, 2015
   - Explanation of reimbursement from Travelers dated April 14, 2016 that shows, "DATE OF BILL: 03/29/2016" and "DATE BILL RECEIVED: 04/01/2016".

   28 Texas Administrative Code RULE §133.20 (b) states in pertinent part,

   > Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided. In accordance with subsection (c) of the statute, the health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill. A health care provider who submits a medical bill to the correct workers' compensation insurance carrier shall include a copy of the original medical bill submitted, a copy of the explanation of benefits (EOB) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied.

   Texas Labor Code §408.027(a) states that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." 28 Texas Administrative Code §102.4(h) states that:

   > Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on:
   > (1) the date received, if sent by fax, personal delivery or electronic transmission or,
   > (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday.

   Review of the submitted information finds documentation (explanation of benefits from Travelers) to support that a medical bill was submitted within 95 days from the date the services were provided. Consequently, the services in dispute will be reviewed per applicable rules and fee guidelines.

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."

   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 $56.2…"

The requestor billed CPT code 01992-QZ 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." The requestor billed the disputed anesthesiology service using the "QZ" modifier that is described as "CRNA service: without medical direction by a physician."

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 0837 and ended at 0910, for a total of 33 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 33/15 = 2.2.
The base unit for CPT code 01992 is 5.
The DWC Conversion Factor is $56.2.

The MAR for CPT code 01630-QZ is: (Base Unit of 5 + Time Unit of 2.2 X $56.2 DWC conversion factor = $404.64.

3. The total allowable for the service in dispute is $404.64. The carrier previously paid $0.00. The remaining balance of $404.64 is due to the requestor.

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 $404.64.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $404.64, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

	Peggy Miller	August 29, 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.