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
TEXAS UNITED ANESTHESIA

Respondent Name
NATIONAL FIRE INSURANCE CO OF HARTFORD

MFDR Tracking Number
M4-18-3878-01

Carrier's Austin Representative
Box Number 57

MFDR Date Received
JUNE 11, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Preauthorization obtained by Dr. Pawn Grover, MD…Your company admitted liability pursuant to verification of benefits…Your refusal to promptly pay for the services rendered is considered negligence and an obvious misrepresentation of coverage on your part."

Amount in Dispute: $3,416.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The claim recently went to a Benefit Contested Case Hearing concerning the extent of the compensable injury. The Decision was sent to the Carrier by cover letter dated June 18, 2018. The Carrier is in the process of reviewing bills that had been denied on the basis of extent to ensure appropriate payments are made in accord with the CCH Decision, Division Rules and the Texas Labor Code."

Response Submitted by: Law Office of Brian J. Judis

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 13, 2017	Anesthesia Services CPT Code 01936-QK	$1,176.00	$0.00
	Anesthesia Services CPT Code 01936-QX	$1,120.00	$230.00
January 8, 2018	Anesthesia Services CPT Code 00300-QX	$1,120.00	$230.32
TOTAL		$3,416.00	$460.32

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 services in dispute were reduced/denied by the respondent with the following reason code:
   - 167, XB52-This (these) diagnosis(es) is (are) not covered.
   - U301-This item was previously submitted and reviewed with a notification of decision issued to payor, provider (duplicate invoice).
   - P4-Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment.

Issue

1. Does a compensability issue exist in this dispute?
2. Is the requestor entitled to reimbursement for CPT code 01936-QK and 01936-QX?
3. Is the requestor entitled to reimbursement for CPT code 00300-QX?

Findings

1. The requestor is seeking medical fee dispute resolution for unpaid anesthesiology services rendered on November 13, 2017 and January 8, 2018.

   According to the explanation of benefits, the respondent denied reimbursement for the disputed services based upon a lack of compensability. The respondent did not maintain this position and wrote, "The claim recently went to a Benefit Contested Case Hearing concerning the extent of the compensable injury. The Decision was sent to the Carrier by cover letter dated June 18, 2018. The Carrier is in the process of reviewing bills that had been denied on the basis of extent to ensure appropriate payments are made in accord with the CCH Decision, Division Rules and the Texas Labor Code." The division concludes that the compensability issue has been resolved and is not an issue in this dispute.

2. For date of service November 13, 2017, the requestor billed CPT codes 01936-QK and 01936-QX. To determine if the disputed services are eligible for reimbursement the division refers to the following statute and Medicare policies:

   - 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…"
   - Medicare Claims Processing Manual, Chapter 12, Qualified Nonphysician Anesthetist and an Anesthesiologist in a Single Anesthesia Procedure, Section 140.4.2, effective January 1, 2017 states, "Where a single anesthesia procedure involves both a physician medical direction service and the service of the medically directed qualified nonphysician anesthetist, 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. For the single medically directed service, the physician will use the QY modifier and the qualified nonphysician anesthetist will use the QX modifier."

- Per Medicare Claims Processing Manual, Chapter 12, Physicians/Nonphysician Practitioners, Payment for Anesthesiology Services, Section (50)(C), effective January 1, 2017, Payment at the Medically Directed Rate:

  The A/B MAC determines payment at the medically directed rate for the physician on the basis of 50 percent of the allowance for the service performed by the physician alone. Payment will be made at the medically directed rate if the physician medically directs qualified individuals (all of whom could be CRNAs, anesthesiologists' assistants, interns, residents, or combinations of these individuals) in two, three, or four concurrent cases and the physician performs the following activities.
  • Performs a pre-anesthetic examination and evaluation;
  • Prescribes the anesthesia plan;
  • Personally participates in the most demanding procedures in the anesthesia plan, including, if applicable, induction and emergence;
  • Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual;
  • Monitors the course of anesthesia administration at frequent intervals;
  • Remains physically present and available for immediate diagnosis and treatment of emergencies; and
  • Provides indicated post-anesthesia care.

  The physician must document in the medical record that he or she performed the pre-anesthetic examination and evaluation. Physicians must also document that they provided indicated post-anesthesia care, were present during some portion of the anesthesia monitoring, and were present during the most demanding procedures in the anesthesia plan, including induction and emergence, where indicated.

  NOTE: Concurrency refers to the maximum number of procedures that the physician is medically directing within the context of a single procedure and whether these other procedures overlap each other. Concurrency is not dependent on each of the cases involving a Medicare patient. For example, if an anesthesiologist medically directs three concurrent procedures, two of which involve non-Medicare patients and the remaining a Medicare patient, this represents three concurrent cases.

  The requirements for payment at the medically directed rate also apply to cases involving student nurse anesthetists if the physician medically directs two concurrent cases, with each of the two cases involving a student nurse anesthetist, or the physician directs one case involving a student nurse anesthetist and another involving a qualified individual (for example: CRNA, anesthesiologist's assistant, intern or resident).

In this dispute, Dr. Benny J. Sanchez billed 01936-QK and John Cook, CRNA billed code 01936-QX.

CPT code 01936 is described as "Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic."

The QK modifier is billed by the physician for "Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals."

The QX modifier is billed for "Qualified nonphysician anesthetist with medical direction by a physician."

The requestor submitted a copy of the Anesthesia Record that indicates Dr. Sanchez was the anesthesiologist and JR Cook was the CRNA. The report does not support activities outlined above for billing the medically directed rate, and "Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals." The division finds the requestor did not support billing 01936 with the "QK" modifier. The division does find that the requestor supported billing 01936-QX; therefore, reimbursement is recommended for CRNA services.

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 15:08 and ended at 16:53, for a total of 45 minutes. Per Medicare Claims Processing Manual, Chapter 12,

Physicians/Nonphysician Practitioners, Payment for Anesthesiology Services, Section (50)(G), effective January 1, 2017, states, "Actual anesthesia time in minutes is reported on the claim. For anesthesia services furnished, 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 45/15 = 3 units.

The base unit for CPT code 01936 is 5.

The DWC Conversion Factor for 2017 is $57.5.

The MAR for CPT code 01936 is: Base Unit of 5 + Time Unit of 3 X $57.5 DWC conversion factor = $460.00. This amount X 50% for QX = $230.00. Previously paid by the respondent is $0.00. The requestor is due the difference between the MAR and amount paid of $230.00.

3. On January 8, 2018, the requestor billed for the CRNA services with CPT code 00300-QX.

   CPT code 00300 is described as "Anesthesia for all procedures on the integumentary system, muscles and nerves of head, neck, and posterior trunk, not otherwise specified."

   A review of the Anesthesia Record supports JR Cook was the CRNA and Dr. Sanchez was the anesthesiologist. The requestor supported billing CPT code 00300-QX; therefore, reimbursement is recommended.

   The Division reviewed the submitted medical bill and finds the anesthesia was started at 14:13 and ended at 14:56, for a total of 43 minutes. Therefore, the requestor has supported 43/15 = 2.9.

   The base unit for CPT code 00300 is 5.

   The DWC Conversion Factor for 2018 is $58.31.

   The MAR for CPT code 00300 is: Base Unit of 5 + Time Unit of 2.9 X $58.31 DWC conversion factor = $460.64. This amount X 50% for QX = $230.32. Previously paid by the respondent is $0.00. The requestor is due the difference between the MAR and amount paid of $230.32.

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 $460.32.

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 $460.32 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		02/05/2019
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, 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.