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
KEARNEY ANESTHESIA ASSOCIATES, PC

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-19-3828-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
APRIL 16, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We were not paid according to Texas work comp fee schedule for anesthesia."

Amount in Dispute: $540.49

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bills were processed in accordance with Rule 42.6(b); Rule 42.10, Kearney Anesthesia Associates is an out of state provider which provider treatment to the claimant under Texas Workers' Compensation Act."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 7, 2018	Anesthesia Services CPT Code 00910-QZ	$184.83	$184.83
	Anesthesia Services CPT Code 99140	$115.29	$0.00
December 21, 2018	Anesthesia Services CPT Code 00860-QZ	$240.37	$240.37
TOTAL		$540.49	$425.20

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, effective May 31, 2012, 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:
   - CAC-P12-Workers' compensation jurisdictional fee schedule adjustment.
   - CAC-W3, 350-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
   - CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - CAC-97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 217-The value of this procedure is included in the value of another procedure performed on this date.
   - 420-Supllemental payment.
   - 790-This charge was reimbursed in accordance to the Texas medical fee guideline.
   - 891-No additional payment after reconsideration.

Issue

1. Does medical fee dispute resolution have jurisdiction to review this dispute?
2. Is the requestor entitled to reimbursement for CPT code 99140?
3. Is the requestor entitled to additional reimbursement for anesthesia services?

Findings

1. The requestor provided anesthesia services in the state of Nebraska on November 7, 2018 and December 21, 2018 to an injured employee with an existing Texas Workers' Compensation claim. The requestor was dissatisfied with the respondent's final action. The requestor filed for reconsideration and was denied payment after reconsideration. The requestor filed for dispute resolution under 28 Texas Administrative Code §133.307. The Division concludes that because the requestor sought the administrative remedy outlined in 28 Texas Administrative Code§133.307 for resolution of the matter of the request for additional payment, the dispute is to be decided under the jurisdiction of the Texas Workers' Compensation Act and applicable rules.

2. According to the explanation of benefits, the respondent denied reimbursement for CPT code 99140 based upon "CAC-97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated," and "217-The value of this procedure is included in the value of another procedure performed on this date."

   On November 7, 2018, the requestor billed CPT codes 00910 and 99140.

   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."

   CPT code 00910 is described as "Anesthesia for transurethral procedures (including urethrocystoscopy); not otherwise specified."

CPT code 99140 is described as "Anesthesia complicated by emergency conditions (specify) (List separately in addition to code for primary anesthesia procedure)."

CPT code 99140 is a bundled code; therefore, the respondent's denial of payment is supported.

3. 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 DWC conversion factor for CY 2018 is $58.31.

   CPT code 00860 is described as "Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; not otherwise specified."

   The QZ modifier is described as "CRNA service: without medical direction by a physician."

   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."

   To determine the MAR the following formula is used: (Time units + Base Units) X Conversion Factor = Allowance.

Code	Time Units	Base Units	MAR	Carrier Paid	Total Due (The difference between MAR and amount paid, or a lesser value sought by Requestor)
00910	80 minutes = 5.3	3	$483.97	$281.65	$184.83
00860	62 minutes = 4.1	6	$588.93	$342.73	$240.37

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 $425.20.

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 $425.20 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	05/13/2019 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.