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
EMERGENCHEALTH, LLC

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-20-2495-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
JUNE 12, 2020

REQUESTOR'S POSITION SUMMARY

"As the anesthesiologist we rely on the facility to provide us with the correct billing information. The face sheet we received indicated the correct insurance carrier for this service was BLUE CORSS BLUE SHIELD -**see ATTACHMENT A.** We billed this carrier and received payment**- see ATTACHMENT B.** Once we received the payment from BCBS, we billed the patient his coinsurance balance **-see ATTACHMENT C**. Once The patient received the statement he contacted our office to notify us this claim should have been billed to his workers compensation carrier, Texas Mutual Insurance - **see ATTACHMENT D** – The office notes indicating he contacted our office on 02/10/2020. We submitted our claim to Texas Mutual Insurance on the same day the patient notified us of this billing error…Please review the attached information and determine this carrier owes our provider for the service provided."

Amount in Dispute: $544.55

RESPONDENT'S POSITION SUMMARY

"Texas Mutual will reconsider payment upon receipt of recoupment request when resubmitted within 95 days of notification and/or DWC26 from BCBS whichever comes first."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 15, 2019	Anesthesia Services CPT Code 01810-QZ	$544.55	$544.55

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307, effective May 31, 2012, sets out the procedures for resolving medical fee disputes.

2. Texas Labor Code (TLC) §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
3. TLC §408.0272, effective September 1, 2007, provides for exceptions for timely submission of a claim by a health care provider.
4. 28 TAC §102.4(h), effective May 1, 2005, sets out rules to determine when written documentation was sent.
5. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
6. The services in dispute were reduced / denied by the respondent with the following reason codes:
   - CAC-29-The time limit for filing has expired.
   - 731-Per Rule 133.20(B) providers shall not submit a medical bill later than the 95th day after the date the service.
   - CAC-W3, 350-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
   - 891-No additional payment after reconsideration.
   - CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Is the requestor entitled to reimbursement for CPT code 01810-QZ rendered on October 15, 2019?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $544.55 for CPT code 01810-QZ rendered on October 15, 2019.

2. The respondent denied reimbursement for the disputed services based upon "CAC-29-The time limit for filing has expired."

3. To determine if the disputed services are eligible for reimbursement the DWC refers to the following statute:

   - TLC §408.027(a) states, "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. 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."

   - TLC §408.0272(b)(1) states "Notwithstanding Section 408.027, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.027(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if: (1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with: (A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured; (B) a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee; or (C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title."

   - 28 TAC §133.20(b) states, "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. The medical bill submitted by the health care provider to the correct workers' compensation insurance carrier is subject to the billing, review, and dispute processes established by Chapter 133, including §133.307(c)(2)(A) - (H) of this title (relating to MDR of Fee Disputes), which establishes the generally acceptable standards for documentation."

   - 28 TAC §102.4(h), states, "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."

4. Both parties to this dispute submitted documentation for consideration in support of their position. The DWC reviewed all the documentation and finds:

   - The date of service in dispute is October 15, 2019.
   - The requestor initially billed and was paid for the disputed service by BCBS.
   - On February 10, 2020, the claimant notified the requestor that this claim should have been billed to Texas Mutual.
   - The requestor supported position that they meet exception for timely filing outlined in TLC §408.0272(b)(1)(A) because billed the claimant's private insurance.
   - On February 10, 2020, the requestor billed the respondent for the disputed services. This date is within the 95 day deadline to bill the correct carrier upon notification of the provider's erroneous submission of bill.
   - The requestor supported position that reimbursement is due.

5. The fee guidelines for disputed services is found at 28 TAC §134.203.

   - 28 TAC §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 TAC 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."

6. CPT code 01810 is described as "Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand." The requestor appended modifier "QZ- CRNA service: without medical direction by a physician" to code 01810.

7. 28 TAC §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."

8. Per Medicare Claims Processing Manual, Chapter 12, Physicians/Nonphysician Practitioners, Payment for Anesthesiology Services, Section (50)(B), effective January 1, 2017, states, "The physician and the CRNA (or anesthesiologist's assistant) are involved in one anesthesia case and the services of each are found to be medically necessary. Documentation must be submitted by both the CRNA and the physician to support payment of the full fee for each of the two providers. The physician reports the AA modifier and the CRNA reports the QZ modifier. "

   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." The requestor billed for 93 minutes; therefore, 93/15 = 6.2.

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

   The 2019 DWC conversion factor for this service is 59.19.

Code	Time Units	Base Units	MAR or §134.203 (h) Lesser of MAR billed amount	Carrier Paid	Total Due
01810	6.2	3	$544.55	$0.00	$544.55

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 $544.55.

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 $544.55 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		07/09/2020
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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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 DWC. **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.