TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Medical Center Health System

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-22-0591-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
November 24, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 4, 2020	00790 QK P4	$60.32	$60.32
	Total	$60.32	$60.32

Requestor's Position

The requestor did not submit a position statement but did submit a copy of their reconsideration that states, "Per EOB expected reimbursement was partially paid. Per the TX WC guidelines for anesthesia the calculation is: (Quantity Billed / Time Divisor) + basic unit x conversion factor. Please review and submit remaining balance due."

Amount in Dispute: $60.32

Respondent's Position

The Austin carrier representative for Texas Mutual is Texas Mutual. The representative was notified of this medical fee dispute on November 30, 2021.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available

information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

Findings and Decision

Authority

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

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203 set out the fee guideline for the reimbursement of workers' compensation professional medical services.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- P12- Workers compensation jurisdictional fee schedule adjustment.
- 144 – Incentive Adjustment E G Preferred product/service
- 192 – This provider has been reimbursed the additional HPSA amount
- 344 – Reduction due to physician supervision of a qualified non-physician anesthetist
- 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
- 420 – Supplemental payment
- 193 – Original payment decision is being maintained upon review it was determined this claim was processed properly

Issues

1. Is the requestor entitled to additional reimbursement for code 00790-QK-P4?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $60.32 for CPT code 007900-QK-P4 rendered on December 4, 2020.

The respondent paid $491.61 for CPT code 00790-QK-P4 based upon the fee schedule.

DWC Rule 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."

DWC Rule 28 TAC §134.203(c)(1) states in pertinent part, "…To determine to MAR for professional services, system participants shall apply the Medicare payment policies with minimal modification… For service categories of Anesthesia, and Surgery when performed in a surgical setting the established conversion factor to be applied is applicable year conversion factor."

DWC Rule 28 TAC §134.203(a)(7) states in pertinent part specific provisions contained in the Texas Labor Code or Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by CMS in administering the Medicare program takes precedence over Medicare payment policies.

The requestor billed the disputed anesthesiology service using the "QK" modifier that is described as "Medical direction of two, three or four concurrent anesthesia procedures involving qualified individual."

The applicable Medicare payment policy for anesthesia is found at www.cms.gov, Medicare Claims Processing Manual, Chapter 12, Qualified Nonphysician Anesthetist and an Anesthesiologist in a Single Anesthesia Procedure Section 140.4.2. *"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."*

Additionally, per the Medicare Claims Processing Manual, Chapter 12, Physicians/Nonphysician Practitioners, Payment for Anesthesiology Services Section (50)(A), General Payment Rule, *"The fee schedule amount for physician anesthesia services furnished is, with the exceptions noted, based on allowable base and time units multiplied by an anesthesia conversion factor specific to that locality."*

Section (50)(G), of Chapter 12 of the Medicare Claims Processing Manual 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 DWC Conversion Factor = Allowance.

Review of the submitted medical bill found a total of 140 units was submitted. The total units 140/15 = 9.333 = 9.3.

The base unit for CPT code 00790 is 7.

The place of service indicated on the medical bill was 21 – Inpatient Hospital. The 2021 DWC

Conversion factor for component of surgery code performed in a facility is 76.76.

Using the above formula, the MAR for CPT code 00790-QK-P4 is,

- (Time units + Base units) 9.3 + 7 = 16.3
- Multiplied by DWC conversion factor 16.3 x 76.76 = $1,251.19
- Divided by 50% for QK = $625.59

The total allowable for code 00790 QK P4 = $625.59. The insurance carrier paid $491.61. The requestor is seeking $60.32 this amount is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Texas Mutual Insurance must remit to Medical Center Health System $60.32 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		June 7, 2022
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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call

CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.