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
Global Anesthesia Services PLLC

Respondent Name
Starnet Insurance Co

MFDR Tracking Number
M4-22-0701-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
December 10, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 23, 2021	CPT Code 01630-QZ	$1,021.42	$1,021.42
	CPT Code 64415-59-LT	$136.41	$136.41
	CPT Code 76942-26	$53.51	$53.51
	Total	$1,211.34	$1,211.34

Requestor's Position

"I have spoken to the adjuster @ York, Debra Williams, and she could see the EOB in their system…She stated the patient's claim was transferred to Galagher Bassett effective 06/01/2021 and the EOB from York is dated 06/09/2021…Please review the attached information and determine this carrier owed our provider for the service provided."

Amount in Dispute: $1,211.34

Respondent's Position

"Supplemental response will be provided once the bill auditing company has finalized their review."

Response Submitted By: Gallagher Bassett

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 §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
3. TLC §408.0272 provides for exceptions for timely submission of a claim by a health care provider.
4. 28 TAC §133.20 sets out the rule for medical bill submission.
5. 28 TAC §102.4(h) sets out rules to determine when written documentation was sent.
6. 28 TAC §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.

Denial Reasons

The insurance carrier [reduced or denied] the payment for the disputed services with the following claim adjustment codes:

- 29-The time limit for filing has expired.
- 5721-To avoid duplicate bill denial, for all reconsiderations/adjustments/additional payment requests submit a copy of this EOR or clear notation that recon is.
- 4063-Reimbursement is based on the physician fee schedule when a professional service was performed in the facility setting.
- P12-Workers' compensation jurisdictional fee schedule adjustment.
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Is Starnet Insurance Company's denial based on timely filing supported?

2. Is Global Anesthesia Services PLLC entitled to additional reimbursement?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $1,211.34 for CPT codes 01630-QZ, 64415-59-LT, and 76942-26 rendered on April 23, 2021.

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

   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."

   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 April 23, 2021.
- CPT codes 01630-QZ, 64415-59-LT, and 76942-26 were denied reimbursement based upon time limit for filing claim had expired.
- The requestor submitted an EOB from York that noted carrier received May 19, 2021. This date is within the 95-day timeline to submit a bill.
- On August 23, 2021 the requestor was notified that York no longer handled the claim and to submit bill to Gallagher Bassett.
- The requestor submitted an EOB from Gallagher Bassett dated September 10, 2021. This date is within the 95-day timeline to submit a bill.
- TLC §408.0272(b)(1) provides for the exception to timely filing based upon three scenarios noted above.
- The requestor supported that the bill was sent to an insurer that meets one of the exceptions for timely filing.
- The requestor supported that the claim was submitted to the respondent within the 95 day deadline set out in Texas Labor Code §408.0272(b)(1).
- The respondent's denial of payment based upon timely filing is not supported.

2. 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."

A. CPT Code 01630-QZ:

CPT code 01630-QZ is described as "Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified." The requestor appended modifier "QZ- CRNA service: without medical direction by a physician" to code 01630.

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."

Per Medicare Claims Processing Manual, Chapter 12, Physicians/Nonphysician Practitioners, Payment for Anesthesiology Services, Section (50)(B), effective January 1, 2021, 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, 2021, 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 179 minutes; therefore, 179/15 = 11.9

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

The 2021 DWC conversion factor for this service is 61.17.

Code	Time Units	Base Units	MAR or §134.203 (h) Lesser of MAR billed amount	Carrier Paid	Total Due
01630	11.9	5	$1,033.77, the requestor is seeking lesser of $1,021.42	$0.00	$1,021.42

B. CPT Code 64415-59-LT:

CPT code 64415 is described as "Injection(s), anesthetic agent(s) and/or steroid; brachial plexus."

Per the National Correct Coding Initiative Policy Manual for Medicare Services, Chapter 2, (B)(4) effective January 1, 2021, states, "Under certain circumstances, an anesthesia practitioner may separately report an epidural or peripheral nerve block injection (bolus, intermittent bolus, or continuous infusion) for postoperative pain management when the surgeon requests assistance with postoperative pain management."

The requestor supported position that CPT code 64415-59-LT is reimbursable because was for postoperative pain management.

28 TAC §134.203(c)(1) states "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) 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 $52.83."

28 Texas Administrative Code §134.203(c)(2) states "The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = Maximum Allowable Reimbursement (MAR).

- Review of Box 32 on the CMS-1500 finds that the services were rendered in zip code 79707 which is located in Midland, Texas; therefore, the Medicare locality is "Rest of Texas."
- The carrier code for Texas is 4412 and the locality code for Rest of Texas is 99.
- The Medicare participating amount for CPT code 64415 at this locality is $62.01
- The Place of Service is 24-Ambulatory Surgical Care Facility.
- The DWC conversion factor for 2021 is 76.76.

  The Medicare conversion factor for 2021 is 34.8931.

Using the above formula, the MAR is $136.41. The respondent paid $0.00. The difference between MAR and amount paid is $136.41; this amount is recommended for reimbursement.

C. 76942-26:

CPT code 76942 is described as "Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation." The requestor appended modifier "26-Professional services" to code 76942.

- The Medicare participating amount for CPT code 76942-26 at this locality is $30.52

Using the above formula, the MAR is $67.14 or less. The requestor is seeking $53.51. The respondent paid $0.00. The difference between MAR and amount paid is $53.51; this amount is recommended for reimbursement.

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 of $1,211.34 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 Starnet Insurance Co. must remit to Global Anesthesia Services PLLC $1,211.34 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	03/14/2022 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.