TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Northstar Anesthesia, PA

Respondent Name
Texas Mutual Insurance Co.

MFDR Tracking Number
M4-22-1210-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
February 22, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 23, 2021	CPT Code 01712-QY-P2 (83)	$3,124.00	$0.00
	CPT Code 64415	$1,756.00	$0.00
	CPT Code 76942-26	$714.00	$13.90
	Total	$5,594.00	$13.90

Requestor's Position

"Per the attached records, the diagnosis on the claim is the one listed in the medical record, and we do not have any other information to code more specifically."

Amount in Dispute: $5,594.00

Respondent's Position

"Documentation submitted does not confirm the Anesthesia Assistant billed under direction of the MD. Payment was issued in error…Payment was issued to the MD on 6/4/21."

Response Submitted By: Texas Mutual Insurance Company

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. 28 TAC §134.203 sets out the reimbursement guidelines for professional services.

Denial Reasons

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

- CAC-18-Exact duplicate claim/service.
- CAC-4-The procedure code is inconsistent with the modifier used or a required modifier is missing.
- 224-Duplicate charge.
- 732-Accurate coding is essential for reimbursement modifier billed incorrectly or missing. Services are not reimbursable as billed.

Issues

1. Is Texas Mutual Insurance Company's denial of payment based upon incorrect billing or modifier supported?
2. Is Northstar Anesthesia, PA entitled to additional reimbursement for 01712-QY services?
3. Is Northstar Anesthesia, PA entitled to additional reimbursement for 64415-59-RT?
4. Is Northstar Anesthesia, PA entitled to additional reimbursement for 76942-26?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $5,594.00 for Assistant Anesthesia services rendered on April 23, 2021.

   According to the explanation of benefits, the carrier paid $0.00 for the disputed service based upon "CAC-4-The procedure code is inconsistent with the modifier used ora required modifier is missing," and "732-Accurate coding is essential for reimbursement modifier billed incorrectly or missing. Services are not reimbursable as billed."

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

   DWC Rule 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."

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."

The requestor billed the following CPT codes:

- 01712-Anesthesia for procedures on nerves, muscles, tendons, fascia, and bursae of upper arm and elbow; tenotomy, elbow to shoulder, open.

  The requestor billed the disputed anesthesiology service using the "QY" modifier that is described as "Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist."
- 64415-Injection(s), anesthetic agent(s) and/or steroid; brachial plexus.
- 76942-Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation.

  The requestor billed the disputed service using the "26" modifier that is described as "Professional Component."

A review of the Anesthesiology Report supports CRNA services in conjunction with anesthesiologist services; therefore, the respondent's denial of payment is not supported.

2. Northstar Anesthesia, PA billed for both the anesthesiologist and CRNA services.

   DWC Rule 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…"

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

   Per Medicare Claims Processing Manual, Chapter 12, Physicians/Nonphysician Practitioners, Payment for Anesthesiology Services Section (50)(B) titled Payment at Personally Performed Rate states, "If the physician is involved with a single case with a qualified nonphysician anesthetist (a certified registered nurse anesthetist (CRNA) or an anesthesiologist's assistant)), A/B MACs may pay the physician service and the qualified nonphysician anesthetist service in accordance with the requirements for payment at the medically directed rate."

   Per Medicare Claims Processing Manual, Chapter 12, Physicians/Nonphysician Practitioners, Payment for Anesthesiology Services Section (50)(C) titled Payment at the Medically Directed Rate states, "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."

The Division reviewed the submitted medical bill and finds the anesthesia was started at 0832 and ended at 0955, for a total of 83 minutes.

Per Medicare Claims Processing Manual, Chapter 12, Physicians/Nonphysician Practitioners, Payment for Anesthesiology Services Section (50)(G) states, "Actual anesthesia time in minutes is reported on the claim. For anesthesia services furnished on or after January 1, 1994, 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 83/15 = 5.5.

The base unit for CPT code 01712 is 5.

The DWC Conversion Factor is $61.17.

The MAR for CPT code 01712-QY is: (Base Unit of 5 + Time Unit of 5.5 X $61.17 DWC conversion factor = $642.29 X 50% = $321.14. The MAR for the anesthesiologist is $321.14. The respondent paid the requestor for both providers services a total of $642.29. As a result, additional reimbursement is not recommended.

3. The requestor is seeking reimbursement of $1,756.00 for CPT code 64415. The respondent paid $136.41 based upon the fee guideline.

   DWC Rule 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."

   DWC 28 TAC §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).

   - Services were rendered in place of service code 22-On-campus Outpatient Hospital.
   - The DWC conversion factor for 2021 is 76.76.
   - The Medicare conversion factor for 2021 is 34.8931.

- Review of Box 32 on the CMS-1500 finds that the services were rendered in zip code 76401 which is located in Stephenville, Texas; therefore, the Medicare locality is "Rest of Texas."
- The Medicare participating amount for CPT code 64415 at this locality is $62.01.

Using the above formula, the MAR is $136.41. The respondent paid $136.41. The difference between MAR and amount paid is $0.00.

4. The requestor is seeking reimbursement of $714.00 for CPT code 76942-26. The respondent paid $53.50 based upon the fee guideline.
   - The Medicare participating amount for CPT code 76942-26 at this locality is $30.52.

   Using the above formula the MAR is $67.14. Based upon the payment of $53.50, the requestor is due the difference of $13.90.

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 $13.90 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 Co. must remit to Northstar Anesthesia $13.90 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	May 13, 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.