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

General Information

Requester Name
STRATUS ANES. ASSOC. SOUTHLAKE, PLLC

Respondent Name
WC SOLUTIONS

MFDR Tracking Number
M5-25-2977-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
July 21, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 3, 2024	01630-AA	$712.01	$712.01
September 3, 2024	64415-59	$136.40	$136.40
	Total	$848.41	$848.41

Requester's Position

"The carrier denied payment of our claim for timely filing. We sent a reconsideration request and provided all the necessary documentation to show why this claim was not billed to Edwards Risk before the timely filing deadline. We received a 2nd denial stating, 'the original payment decision was maintained - it was determined this claim was processed properly.' We contacted the facility where our anesthesia services were rendered and learned that Edwards Risk issued payment to that entity for services on this same date for this patient - see Attachment A. If the facility is eligible for payment, the anesthesia provider is due payment for services to this patient."

Excerpt from the Requester's request for reconsideration dated June 2, 2025:

"As the anesthesiologist, we rely on the facility where our services were rendered to provide us with the correct billing information. We received the attached face sheet - see Attachment A - indicating that we were to bill our claim to BLUE CROSS BLUE SHIELD for processing. Our claim was billed to BLUE CROSS BLUE SHIELD, and they issued payment to us via remittance notice dated 10/03/2024… On 04/23/2025 our office received an email… stating this patient's attorney

contacted them and provided the patient's workers compensation insurance information… " We submitted our claim to the correct carrier on day after we learned of our billing error."

Amount in dispute: $848.41

Respondent's Position

"The medical bill was not submitted to the carrier until April 28, 2025. The provider was required to submit the bill to the workers' comp carrier no later than the 95th day following the date of service… The provider's request for reconsideration dated June 2, 2025, provided an explanation for the late submission of the bill to the correct carrier… the request for reconsideration letter does not indicate whether the provider's submission of the medical bill to the correct carrier was within 95 days of the date that the provider was notified of its previous erroneous submission. The Carrier's position currently is that the provider failed to bring itself within section 408.027 and 408.0272. Accordingly, the Carrier's position is that the provider is not entitled to reimbursement."

Response submitted by: Flahive, Ogden & Latson

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §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, effective February 22, 2021, sets out the procedures for resolving medical fee disputes.
2. 28 TAC §133.20 sets out requirements of timely medical bill submission.
3. TLC 408.0272 sets out certain exceptions for untimely submission of a medical claim.
4. 28 TAC §134.203 set out the fee guideline for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.

Denial Reasons

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

- 29 - THE TIME LIMIT FOR FILING HAS EXPIRED.
- 4271 - PER TX LABOR CODE SEC. 408.027, PROVIDERS MUST SUBMIT BILLS TO PAYORS WITHIN 95 DAYS OF THE DATE OF SERVICE.
- W3 – RECONSIDERATION.
- 193 - ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WA S PROCESSED PROPERLY.

- 1241 - NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION/REQUEST FOR SEC OND REVIEW.
- 6000 - REQUEST FOR RECONSIDERATION.

Issues

1. Has the requester waived its right to medical fee dispute resolution (MFDR)?

2. Is the requester entitled to reimbursement for the disputed service billed under procedure code 01630-AA?

3. Is the requester entitled to reimbursement for the disputed service billed under procedure code 64415-59?

Findings

1. A review of the submitted explanation of benefits (EOB) as well as both parties' position statements finds that the services in dispute were denied due to untimely filing of the medical bill.

   28 TAC §133.20 which sets out requirements of timely medical bill submission, states in pertinent part "(b) 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."

   Texas Labor Code §408.0272(b) which sets out certain exceptions for untimely submission of a claim, states "(b) 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; or (2) the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider." TLC §408.0272(c) goes on to further state, "Notwithstanding Subsection (b), a health care provider who erroneously submits a claim for payment to an entity described by Subdivision (1) of that subsection forfeits the provider's right to

reimbursement for that claim if the provider fails to submit the claim to the correct workers' compensation insurance carrier within 95 days after the date the provider is notified of the provider's erroneous submission of the claim."

A review of the documentation submitted finds sufficient evidence to support that the requester erroneously submitted the medical claim to the injured employee's health insurance carrier within 95 days of the disputed date of service. The submitted evidence further supports that the requester was notified of the erroneous claim submission on April 23, 2025, and that the correct workers' compensation carrier then received the medical claim on April 28, 2025, less than 95 days after notification of the erroneous claim submission.

Per the documentation submitted, DWC finds that the requester has not waived its right to MFDR. Therefore, the services in dispute will be reviewed for reimbursement.

2. The requester is seeking reimbursement in the amount of $712.01 for anesthesia service billed under procedure code 01630-AA, rendered in an outpatient hospital on September 3, 2024.

   Procedure code 01630 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 requester appended the procedure code with modifier "AA" to indicate anesthesia services were performed personally by the anesthesiologist.

   DWC finds that 28 TAC §134.203 is applicable to the reimbursement of the service in dispute.

   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."

   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 …"

   Per Medicare Claims Processing Manual, Chapter 12, Physicians/Nonphysician Practitioners, Payment for Anesthesiology Services Section (50)(A), effective January 1, 2017, 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."

A review of the medical records and medical bill submitted confirms that on the disputed date of service, the anesthesia services billed under CPT code 01630-AA started at 07:10 and ended at 08:33, for a total of 83 minutes.

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." Therefore, the requester has supported 83/15 = 5.5 units of time.

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

- The base unit for CPT code 0163 is 5.
- The 2024 DWC Conversion Factor on the disputed date of service is 67.81.
- Using the above formula, the MAR for CPT code 0163-AA is 5.5 + 5 = 10.5 X 67.81= $712.01.
- The insurance carrier paid $0.00.
- Reimbursement in the amount of $712.01 is recommended for CPT code 0163 rendered on September 3, 2024.

DWC finds that the requester is entitled to reimbursement in the amount of $712.01 for anesthesia service provided on September 3, 2024, billed under procedure code 0163-AA.

3. The requester is seeking reimbursement in the amount of $136.40 for anesthesia service billed under procedure code 64415-59-LT, rendered in an outpatient hospital on September 3, 2024.

   Procedure code 64415 is described as "Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, including imaging guidance, when performed." The requester appended the procedure code with modifier "59" to indicate the procedure is a separately identifiable service and with modifier LT to indicate the left anatomical side of the body.

   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."

   A review of the medical records submitted finds that the requester supported that CPT code 64415-59-LT is separately reimbursable as a postoperative pain management service.

   28 TAC §134.203(c)(1), which applies to the disputed service, 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..."

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."

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

- The disputed date of service is September 3, 2024.
- The disputed service was rendered in zip code 75146, locality 11, "Dallas."
- The Place of Service is 24-Ambulatory Surgical Care Facility.
- The Medicare participating amount for CPT code 64415 on the disputed date of service at this locality is $68.69.
- The 2024 DWC Surgery Conversion Factor is 85.12.
- The 2024 Medicare Conversion Factor on the applicable date of service is 33.2875.
- Using the above formula, DWC finds the MAR is $175.65 for CPT code 64415 on the disputed date of service.
- The respondent paid $0.00.
- The requester is seeking reimbursement in the amount of $136.40. Therefore, this amount is recommended.

DWC finds that the requester is entitled to reimbursement in the amount of $136.40 for the disputed anesthesia service provided on September 3, 2024, billed under procedure code 64415-59-LT.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requester 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 reimbursement is due in the total amount of $848.41 for the disputed anesthesia services rendered on September 3, 2024.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to reimbursement for the disputed services. It is ordered that respondent, WC Solutions, must remit to the requester, Stratus Anes. Assoc. Southlake, PLLC., $848.41 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	September 11, 2025 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.