



**Texas Department of Insurance**

**Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48  
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645  
512-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

**MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

**GENERAL INFORMATION**

**Requestor Name**

SILVIA OLEJNIKOVA, MD

**Respondent Name**

INDEMNITY INSURANCE CO OF NORTH AMERICA

**MFDR Tracking Number**

M4-15-0220-01

**Carrier's Austin Representative**

Box Number 15

**MFDR Date Received**

SEPTEMBER 15, 2014

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Line item 2 code billed 64415, is for a INJECTION, ANESTHETIC AGENT; BRACHIAL PLEXUS, SINGLE, this code is billed as a type service 2 with **added modifier 59** to identify it as a distinct procedural service (not inclusive, not incidental). Medicare will pay for post-operative pain management nerve blocks billed exactly as we have submitted this bill."

**Amount in Dispute:** \$495.00

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "Requestor originally billed CPT code 64415 with no modifier. Thereore, Respondent correctly denied payment for this code as it is bundled with the billed CPT code 01630, which was paid. Requestor then added a modifier upon reconsideration for the sole pupose of obtaining reimbursement. This is a direct violation of DWC Rule 133.250(d). Therefore, Respondent stands by its original denial."

**Response Submitted By:** Downs Stanford, PC

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 10, 2014	CPT Code 64415 Injection	\$495.00	\$186.66

**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.

**Background**

- 28 Texas Administrative Code §134.203 set out the fee guideline for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.

2. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 97-the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
  - 903-In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code Editor), component code of comprehensive surgery: Endocrine, Nervous, Eye and Ocular Adnexa, Auditory Systems Procedure (60000-69999) has been disallowed.
  - 247-A payment or denial has already been recommended for this service.
  - B13-Previously paid. Payment for this claim/service may have been provided in a previous payment.

**Issues**

1. Is the allowance of code 66415 included in the allowance of 01630-QK?
2. Is the requestor entitled to reimbursement for code 66415?

**Findings**

1. 28 Texas Administrative Code §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 Texas Administrative Code 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.”

According to the explanation of benefits, the respondent denied reimbursement for CPT code 64415 based upon reason code “97.”

The 2014 National Correct Coding Initiatives Manual, Chapter 2, states “A peripheral nerve block injection (CPT codes 64XXX) for postoperative pain management may be reported separately with an anesthesia 0XXXX code only if the mode of intraoperative anesthesia is general anesthesia, subarachnoid injection, or epidural injection, and the adequacy of the intraoperative anesthesia is not dependent on the peripheral nerve block injection.” The requestor indicated the nerve block was for post-operative pain management.

Per CCI edits, CPT code 64415 is not bundled to 01630-QK; therefore, reimbursement is recommended.

2. Per 28 Texas Administrative Code §134.203(c)(1)(2), “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. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32.

(2) 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 Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2014 DWC conversion factor for this service 55.75.

The Medicare Conversion Factor is 35.8228.

Review of Box 32 on the CMS-1500 the services were rendered in zip code 78746, which is located in Austin, Texas; therefore, the Medicare Participating Amount is based upon the locality of “Austin, Texas”.

The Medicare participating amount is \$119.94.

Using the above formula, the Division finds the MAR is \$186.66. The respondent paid \$0.00. As a result, the requestor is entitled to reimbursement of \$186.66.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$186.66.

**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 \$186.66 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

		02/05/2015
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 Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division 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 Division. **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**