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 PLL

Respondent Name
Insurance Co of the State of PA

MFDR Tracking Number
M4-23-0275-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
September 30, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 20, 2022	76942 26	$52.10	$52.10
	Total	$52.10	$52.10

Requestor's Position

"The carrier denied payment of Code 76942 26 stating medical necessity has not been established for this procedure. We sent a reconsideration request stating this procedure is performed on a case by case basis and the provider determines necessity of the procedure when there is difficulty placing the needle placement for the pain block."

Amount in Dispute: $52.10

Respondent's Position

The Austin carrier representative for Insurance Co of the State of PA is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on October 4, 2022.

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 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §137.100 sets out for retrospective review.
3. 28 TAC §133.240 sets out the requirements of medical necessity denials.
4. 28 TAC §134.203 sets out the fee guideline for professional services.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- 1 – Workers' compensation jurisdictional fee schedule adjustment
- 2 – The charge for the procedure exceeds the amount indicated in the fee schedule
- 3 – Medical necessity has not been established for this procedure

Issues

1. Did the respondent deny disputed charge per division rules?
2. What rule is applicable to the fee guideline of the disputed service?
3. Is the requestor entitled to additional payment?

Findings

1. Review of the submitted documentation finds that CPT Code 76942 26 denied due to unresolved issues of medical necessity.

   DWC Rule 28 Texas Administrative Code §137.100 (e) states, "An insurance carrier may retrospectively review, and if appropriate, deny payment for treatments and services not preauthorized under subsection (d) of this section when the insurance carrier asserts that health care provided within the Division treatment guidelines is not reasonably required. The

assertion must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017."

In addition, 28 Texas Administrative Code §133.240 (q) states, in relevant part, "When denying payment due to an adverse determination under this section, the insurance carrier shall comply with the requirements of §19.2009 of this title ... Additionally, in any instance where the insurance carrier is questioning the medical necessity or appropriateness of the health care services, the insurance carrier shall comply with the requirements of §19.2010 of this title ..., including the requirement that prior to issuance of an adverse determination the insurance carrier shall afford the health care provider a reasonable opportunity to discuss the billed health care with a doctor ..."

Submitted documentation does not support that the insurance carrier followed the appropriate procedures for a retrospective review denial of the disputed services outlined in §19.2003 (b)(31) or §133.240 (q). Therefore, the insurance carrier did not appropriately raise medical necessity for this dispute. The services in dispute will be reviewed per applicable fee guidelines.

2. DWC Rule 28 TAC §134.203 (c) states in pertinent part, to determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an facility setting, the established conversion factor to be applied is the conversion factor for the date of service in dispute.

   The Medicare physician fee schedule allowable for Midland, Texas is $30.27. The calculation of the maximum allowable reimbursement (MAR) is DWC conversion factor divided by then Medicare conversion factor multiplied by the Medicare physician fee schedule or $62.46/$34.6062 x $30.27 equals $54.63.

3. The MAR for the disputed service is $54.63. The requestor is seeking $52.10. 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 respondent must remit to requestor $52.10 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		February 1, 2023
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.