TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
DALLAS ANESTHESIA GROUP, PLLC

Respondent Name
EMPLOYERS PREFERRED INSURANCE CO

MFDR Tracking Number
M4-21-0827-01

Carrier's Austin Representative
Box Number 4

MFDR Date Received
JANUARY 20, 2021

REQUESTOR'S POSITION SUMMARY

"The carrier owes payment for all services provided to this patient."

Supplemental Position Summary: "We have received the check for $53.08, but still no allowable for Code 64415 59."

Amount Sought: $190.29

RESPONDENT'S POSITION SUMMARY

"The additional amount of $53.06 was processed 02/08/21, check 3241346099. We also attached a copy of the EOR with an explanation."

Response Submitted by: Employers Services, Inc

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount Sought	Amount Due
September 17, 2020	CPT Code 64415-59	$136.40	$136.40
	CPT Code 76942-26	$53.89	$0.00
Total		$190.29	$136.40

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Background

1. 28 Texas Administrative Code §133.307, effective May 31, 2012, sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
3. The insurance carrier denied/reduced payment for the disputed services with the following claim adjustment codes:
   - 86-Service performed was distinct or independent from other services performed on the same day.
   - P5-Based on payer reasonable and customary fees, no maximum allowable defined by legislated fee arrangement.
   - 298-The recommended allowance is based on the value for the professional component of the service performed.
   - 942-Separate reimbursement for this line item is denied. The clinical information and detail submitted on the procedures rendered, indicates that separate reimbursement for this line would be inappropriate or has been included in the value of the procedure performed.
   - P12-Workers compensation jurisdictional fee schedule adjustment.
   - T13-Medical necessity denial. You may submit a request for an appeal/reconsideration no later than 10 months from the date of service.
   - 4063-Reimbursemetn is based on the physician fee schedule when a professional service was performed in the facility setting.
   - 5211-Nurse audit has resulted in an adjusted reimbursement.
   - W3-Additional payment made on appeal/reconsideration.
   - 5280-No additional reimbursement allowed after review of appeal/reconsideration.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 1001-Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.
   - 1014-The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

Issues

Is the requestor due reimbursement for CPT codes 64415-59-RT and 76942-26 rendered on September 17, 2020?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $190.29 for CPT codes 64415-59-RT and 76942-26 rendered on September 17, 2020.
2. The respondent denied payment for CPT codes 64415-59-RT and 76942-26 based upon "T13-Medical necessity denial. You may submit a request for an appeal/reconsideration no later than 10 months from the date of service." Upon receipt of the request for medical fee dispute resolution, the respondent reconsidered position and issued payment for CPT code 76942-26; therefore, this service is no longer in dispute. The only service in dispute is CPT code 64415-59-RT and the respondent maintained the denial of payment.

   28 TAC §133.307(d) (2)(I) states,

   > (d) Responses. Responses to a request for MFDR must be legible and submitted to the division and to the requestor in the form and manner prescribed by the division. (2) Response. On receipt of the request, the respondent must provide any missing information not provided by the requestor and known to the respondent. The respondent must also provide the following information and records: (I) If the medical fee dispute involves medical necessity issues, the insurance carrier must attach

documentation that supports an adverse determination in accordance with §19.2005 of this title (concerning General Standards of Utilization Review).

The respondent did not submit documentation that supports an adverse determination in accordance with §19.2005; therefore, the medical necessity denial is not supported.

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

4. 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."

5. 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."

6. NCCI Policy Manual for Medicare Services, Chapter 2, (B)(4) effective January 1, 2020 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. An epidural injection (CPT code 623XX) for postoperative pain management may be reported separately with an anesthesia 0XXXX code only if the mode of intraoperative anesthesia is general anesthesia and the adequacy of the intraoperative anesthesia is not dependent on the epidural injection. 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. An epidural or peripheral nerve block injection (code numbers as identified above) administered preoperatively or intraoperatively is not separately reportable for postoperative pain management if the mode of anesthesia for the procedure is monitored anesthesia care, moderate conscious sedation, regional anesthesia by peripheral nerve block, or other type of anesthesia not identified above. If an epidural or peripheral nerve block injection (62320-62327 or 64450-64530 as identified above) for postoperative pain management is reported separately on the same date of service as an anesthesia 0XXXX code, modifier 59 or XU may be appended to the epidural or peripheral nerve block injection code (62320-62327 or 64450-64530 as identified above) to indicate that it was administered for postoperative pain management. An epidural or peripheral nerve block injection (62320-62327 or 64450-64530 as identified above) for postoperative pain management in patients receiving general anesthesia, spinal (subarachnoid injection) anesthesia, or regional anesthesia by epidural injection as described above may be administered preoperatively, intraoperatively, or postoperatively .

The submitted Anesthesia report supports claimant underwent general anesthesia for the surgery, and the surgeon requested an injection for postoperative pain management; therefore, the disputed service is eligible for reimbursement.

7. 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."

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

The place of service is 24 for ambulatory surgery care facility.

The 2020 DWC Conversion Factor is 75.70

The 2020 Medicare Conversion Factor is 36.0896

The Medicare participating amount for code 64415 at locality "Dallas, Texas" is $65.83

Using the above formula, the DWC finds the MAR is $138.08 or less. The requestor is seeking $136.40. The respondent paid $0.00. As a result, reimbursement of $136.40 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $136.40.

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 $136.40 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	04/05/2021 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.