TDI 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
Dallas Anesthesia Group PLLC

Respondent Name
Starr Indemnity & Liability Co

MFDR Tracking Number
M4-24-2131-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
June 3, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 20, 2023	62322 59	$182.05	$153.36
	Total	$182.05	$153.36

Requestor's Position

"The carrier denied payment for Code 62322 59 stating "submitted authorization number is not valid." We are not required to obtain authorization for this code. The surgeon requested the anesthesiologist perform this procedure for post operative pain control, at the time of procedure. The anesthesia provider is not required to obtain authorization."

Amount in Dispute: $182.05

Respondent's Position

"Our initial response to the above referenced medical fee dispute resolution is as follows: we have escalated the bills in question for manual review to determine if additional monies are owed."

Supplemental response submitted June 13, 2024

"We have confirmed that with our [sic] the Fee Schedule Team that the bill was priced appropriately per Fee Schedule and that CPT code 62322, which the provider is disputing the denial of, is denied appropriately per state guidelines as requiring authorization."

Response submitted by: Gallagher Bassett

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 (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.600 sets out the requirements of prior authorization.
3. 28 TAC §134.203 sets out the reimbursement guidelines for professional medical services.

Denial Reasons

- 00663 – Reimbursement has been calculated according to state fee schedule guidelines.
- 90083 – Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.
- 15 – Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.
- 293 – Payment made to employer.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

1. Is the insurance carrier's denial supported?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of Code 62322 - Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance." The insurance carrier denied the disputed charge for lack of prior authorization. The requestor included the 59 modifier on the medical bill. The 59 modifier is defined as, "distinct or independent service form other services rendered on the same day.

   Reivew of the submitted "Anesthesiology" records indicates the time of administration of the injection described by code 62322 was 13:29. The start time of the anesthesia was 13:36 and end time of 15:24. The requestor's use of the 59 modifier is supported.

   DWC Rule 134.600 (p) states in pertinent parts, "Non-emergency health care requiring preauthorization includes:

(1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay;

(2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section;

(3) spinal surgery;

(4) all work hardening or work conditioning services;

(5) physical and occupational therapy services…

(6) any investigational or experimental service or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service, or device but that is not yet broadly accepted as the prevailing standard of care;

(7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized return-to-work rehabilitation program;

(8) unless otherwise specified in this subsection, a repeat individual diagnostic study…

(9) all durable medical equipment (DME) in excess of $500 billed charges per item (either purchase or expected cumulative rental);

(10) chronic pain management/interdisciplinary pain rehabilitation;

(11) drugs not included in the applicable division formulary;

(12) treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier. This requirement does not apply to drugs prescribed for claims under §§134.506, 134.530 or 134.540 of this title (relating to Pharmaceutical Benefits);

(13) required treatment plans; and

(14) any treatment for an injury or diagnosis that is not accepted by the insurance carrier under Labor Code §408.0042 and §126.14 of this title (relating to Treating Doctor Examination to Define the Compensable Injury).

Based on review of the applicable rule shown above, the DWC finds an injection administered separately from the surgical procedure does not require prior authorization. The carrier's denial is not supported. The denied service will be reviewed per the applicable fee guideline.

2. 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."

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.

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…"

The following formula represents the calculation of the DWC MAR at §134.203 (c)(1) & (2).

(DWC Conversion Factor ÷ Medicare Conversion Factor) x Medicare Payment = MAR

64.83/33.8872 x $80.16 (CMS physician fee schedule amount for locality) = $153.36

3. The total allowable DWC fee guideline reimbursement is $153.36. 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 Starr Indemnity & Liability Co must remit to Dallas Anesthesia Group PLLC $153.36 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		June 25, 2024
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.