



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Anesthesia Alliance of Dallas

Respondent Name

Markel Insurance Co

MFDR Tracking Number

M4-26-0403-01

Insurance Carrier's Austin Representative

BOX 17 Downs Stanford PC

DWC Date Received

October 10, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
May 8, 2025	64415 59 LT	\$136.40	\$0.00
Total		\$136.40	\$0.00

Requester's Position

"We have provided the necessary documentation for the procedures performed. We also noted in our reconsideration request that per NCCI edits Code 64415 59 LT was to be reimbursed with appropriate modifier. We billed Modifier 50 indicating a "separate, billable procedure. Please review the attachments and order the carrier to issue payment for this outstanding code".

Amount In Dispute: \$136.40

Respondent's Position

The Austin carrier representative for Markel Insurance Co is Downs Stanford PC. The representative was notified of this medical fee dispute on October 14, 2025.

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 Section [413.031](#) and other applicable laws and rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) Section [133.307](#) sets out the procedures for resolving medical fee disputes.
2. 28 TAC Section [134.203](#) sets out the fee guidelines for professional medical services.

Adjustment Reasons

- 435- Per NCCI Edits, the value of this procedure is included in the value of the comprehensive code.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- G23 – Reimbursement has been calculated according to the Anesthesia fee schedule guidelines.
- D50 – Documentation does not support this code for reimbursement. Results of professional review (RN, MD, DC, CPC, other medica professional)
- 216 – This procedure code was ranked as the primary service when considered for multiple procedure reduction. As a result, no reduction was taken.
- G14 – Pricing is calculated based on the professional fee schedule facility site of service value.
- 252 – An attachment /other documentation is required to adjudicate this claim/service.
- 236 – This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the NCCI or Workers Compensation State Regulations / Fee Schedule requirements.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

- P12 – Workers compensation jurisdictional fee schedule adjustment.

Issues

1. What is DWC considering in this medical fee dispute?
2. What rules(s) are applicable to reimbursement?
3. Is the requester entitled to additional payment?

Findings

1. The requester is seeking reimbursement in the amount of \$136.40 for code 64415-59-LT (Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, including imaging guidance, when performed) for date of service May 8, 2025. The Carrier denied the claim line of the medical bill based on NCCI edits. The Division will review this denial based on the applicable fee guideline.
2. DWC Rule Section 134.203(b) states in pertinent part, 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;

Review of the medical bill indicates that the requester billed CPT codes 01630-AA and 64415-59-LT for the disputed date of service, May 8, 2025. Applicable NCCI edits identify an edit between CPT codes 01630 and 64415. The requester reports appending modifier 59 and states in their position, *"We have provided the necessary documentation for the procedures performed."*

The requirements for modifier 59 state: *"Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision or excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual."*

The documentation submitted, titled "Attachment A," indicates "15:20 Upper Ext. Nerve Block TCMC." This information is insufficient to support a separate and distinct session, procedure, or site. Therefore, the insurance carrier's denial is supported.

3. The insurance carriers denial based on lack of support for use of the 59 modifier is

supported. No payment is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence requester and the respondent presented at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that reimbursement is due.

Order

Under Texas Labor Code Sections [413.031](#) and [413.019](#), DWC has determined the requester is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	January 14, 2026
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 Section [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 800-252-7031, option three 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 this *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC Section [141.1\(d\)](#).

Si prefiere hablar con una persona en español acerca de esta correspondencia, favor de llamar a 800-252-7031, opción tres o correo electrónico CompConnection@tdi.texas.gov.