



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

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

AHMED KHALIFA MD

Respondent Name

PACIFIC EMPLOYERS INSURANCE CO

MFDR Tracking Number

M4-13-3167-01

Carrier's Austin Representative Box

Box Number 15

MFDR Date Received

August 8, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "An audit our record indicated that per the carrier's request the check for an amount of \$118.86 was returned. Hence, we actually never received a payment although the carrier's response of July 17, 2013 to our request for reconsideration shows a full payment of \$165.09 was approved for payment."

Amount in Dispute: \$165.09

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...the Provider submitted the required W-9 on 06-29-2013, and the withholding requirement was lifted. The subsequent submission does not, however, erase the withholding requirement for the time period between the deadline and the submission of the W-9."

Response by: William Weldon.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 5, 2013	99214	\$165.09	\$165.09

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 §133.307 sets out the procedures for resolving a medical fee dispute.
- 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for E/M services.
- 28 Texas Administrative Code §133.240 sets out the guidelines medical bill processing.
- The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- "193" listed with no explanation of denial reason.

Issues

1. Did the carrier issue the explanation of benefits in the form and manner prescribed by the division?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.240 (e), (f) (F-H) states “ (e)The insurance carrier shall send an explanation of benefits in accordance with subsection (f) of this section if the insurance carrier submits the explanation of benefits in paper form...(f) The paper form of an explanation of benefits under subsection (e) of this section, §133.250 of this title (relating to Reconsideration for Payment of Medical Bills), or §133.260 of this title (relating to Refunds) shall include the following elements:...(F) amount paid; (G)adjustment reason code that conforms to the standards described in §133.500 and §133.501 of this title if total amount paid does not equal total amount charged; (H)explanation of the reason for reduction/denial if the adjustment reason code was included under subparagraph (G) of this paragraph and if applicable...” The submitted explanation of benefits (EOB) under the “STATE REQUIRED INFORMATION” section states, in pertinent part, that “The complete ANSI claim adjustment reason code set available on the Washington Publication company Website at www.wpc-edi.com.” Under the section labeled “JURISDICTIONAL CODES” the number “193”; was noted; however the explanation of the reason for reduction/denial was not included.

The Division concludes that the carrier failed to meet the requirements of 28 Texas Administrative Code §133.240. For that reason, the disputed amounts are eligible for payment.

2. For the reason stated above the services in dispute are eligible for reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.203(c) which states, “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.” Review of the submitted documentation finds that the requestor performed an office visit for the evaluation and management of an established patient CPT code 99214 in calendar year 2013. The conversion factor for professional services in 2013 is \$55.30.

Per 28 TAC §134.203 (c) total allowable reimbursement for the services in dispute is: TDI-DWC Conversion Factor / Medicare Conversion Factor) x Non-Facility Price = MAR.

$$(55.30 / 34.023)*\$101.57 = \$165.09$$

The division concludes that the total allowable is 165.09. The respondent issued payment in the amount of \$0. Based upon the documentation submitted, reimbursement in the amount of \$165.09 is recommended

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 \$165.09.

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 \$165.09, 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

Date

July , 2014

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.