



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 A Khalifa

Respondent Name

ACIG Insurance Co

MFDR Tracking Number

M4-14-0163-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

September 16, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...please accept this letter as our request for reconsideration and full payment without any further delay."

Amount in Dispute: \$273.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgement of medical fee dispute received however, no position statement submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 25, 2013	64640 x 3	\$273.90	\$273.90

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 medical fee disputes.
- 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 197 – Payment adjusted for absence of precert/preauth
 - W1 – Workers' Compensation State Fee Schedule Adj
 - W3 – Additional payment on appeal/reconsideration

Issues

- Did the respondent pay in accordance with Division rules and fee guidelines?
- Is the requestor entitled to reimbursement?

Findings

1. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier’s Austin representative box which was acknowledged received on September 24, 2013. The insurance carrier did not submit a response for consideration in this review. Per the Division’s former rule at 28 Texas Administrative Code §133.307(d)(1), effective May 25, 2008, 33 *Texas Register* 3954, “If the Division does not receive the response information within 14 calendar days of the dispute notification, then the Division may base its decision on the available information.” Accordingly, this decision is based on the available information.

2. The Carrier reduced the allowed amount as W1 – “Workers’ Compensation State Fee Schedule Adj. 28 Texas Administrative Code §134.203(b) states in pertinent part, “(b) 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...” Review of the CMS Physician Fee Schedule finds the following:
 - a. Service in dispute is subject to multiple procedural discounting. Medicare Claims Processing Manual, Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS), 10.5 – Discounting. Multiple surgical procedures furnished during the same operative session are discounted. • The full amount is paid for the surgical procedure with the highest weight; Fifty percent is paid for any other surgical procedure(s) performed at the same time; • Similar discounting occurs now under the physician fee schedule and the payment system for ASCs;

The maximum allowable reimbursement (MAR) will be calculated as follows;

Date of Service	Submitted code	Maximum Allowable Reimbursement (MAR) Full amount paid to first procedure, second and third procedure paid at 50 per cent
June 25, 2013	64640	(TDI-DWC Conversion Factor) / Medicare Conversion factor) x Non-Facility Price or $(69.43 / 34.023) \times 138.75 = \283.144
June 25, 2013	64640	$(69.43 / 34.023) \times 69.38$ (138.75 divided by 50%) = \$141.58
June 25, 2013	64640	$(69.43 / 34.023) \times 69.38$ (138.75 divided by 50%) = \$141.58
	Total	\$566.30

Therefore the Division finds the carrier’s reduction is not supported.

3. The total allowable reimbursement for the services provided is \$566.30. The insurance carrier previously paid \$196.17. The requestor is seeking \$273.90. This amount 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 \$273.90.

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 \$273.90 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

August , 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.