



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

Travelers Casualty Ins Co

MFDR Tracking Number

M4-14-2861-01

Carrier's Austin Representative

Box Number 05

MFDR Date Received

May15, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please note from the attached testing results & supporting documentation that all components for this claim were performed and billed appropriately using the TDI-DWC Fee Guidelines and should not be reduced."

Amount in Dispute: \$207.10

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has reviewed the reimbursement calculations related to these procedures and confirmed that reimbursement was properly issued."

Response Submitted by: Travelers Insurance Co

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 12, 2014	99203, 95886, 95911, A4556	\$207.10	\$81.34

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 reimbursement guidelines for professional services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 97 – Charge exceeds fee schedule allowance
 - 5374 – Reimbursement for line item is incl in the payment recommendations

Issues

- Did the requestor support position that additional reimbursement is due?
- Is the requestor entitled to reimbursement?

Findings

1. The carrier reduced the services in dispute as 97 – “Charge exceeds fee schedule allowance.” Per 28 Texas Administrative Code § 134.203 (c) states in pertinent part, “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 (date of service yearly conversion factor).”
 - Procedure code 99203, service date February 12, 2014, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 1.42 multiplied by the geographic practice cost index (GPCI) for work of 1.014 is 1.43988. The practice expense (PE) RVU of 1.47 multiplied by the PE GPCI of 1.004 is 1.47588. The malpractice RVU of 0.13 multiplied by the malpractice GPCI of 0.939 is 0.12207. The sum of 3.03783 is multiplied by the Division conversion factor of \$55.75 for a MAR of \$169.36.
 - Procedure code 95886, service date February 12, 2014, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.86 multiplied by the geographic practice cost index (GPCI) for work of 1.014 is 0.87204. The practice expense (PE) RVU of 1.67 multiplied by the PE GPCI of 1.004 is 1.67668. The malpractice RVU of 0.04 multiplied by the malpractice GPCI of 0.939 is 0.03756. The sum of 2.58628 is multiplied by the Division conversion factor of \$55.75 for a MAR of \$144.19 at 2 units is \$288.38.
 - Procedure code 95910, service date February 12, 2014, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 2 multiplied by the geographic practice cost index (GPCI) for work of 1.014 is 2.028. The practice expense (PE) RVU of 3.07 multiplied by the PE GPCI of 1.004 is 3.08228. The malpractice RVU of 0.12 multiplied by the malpractice GPCI of 0.939 is 0.11268. The sum of 5.22296 is multiplied by the Division conversion factor of \$55.75 for a MAR of \$291.18.
 - Procedure code A4556, service date February 12, 2014, has a status indicator of “B” bundled service. No separate payment can be recommended.
2. The total allowable reimbursement for the services in dispute is \$748.92. This amount less the amount previously paid by the insurance carrier of \$667.58 leaves an amount due to the requestor of \$81.34. 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 \$81.34.

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 \$81.34 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

January , 2015
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.