



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
AHMED KHALIFA, MD

Respondent Name
LIBERTY INSURANCE CORP

MFDR Tracking Number
M4-15-2898-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
MAY 5, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted a request for reconsideration to Liberty Mutual on 7-31-2014, this request was in response to a \$1436.98 no payment of the \$1436.98 for the Office Procedure performed on 7-31-2014. Unfortunately our request was denied ad we are seeking the balance owed to us."

Requestor's Supplemental Position Summary: "They made a partial payment, we are still seeking the \$522.26 balance."

Amount in Dispute: \$1,436.98

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Attached are the payment EOBs (payment and interest)."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. It lists medical services performed on July 31, 2014, including various injection procedures with CPT codes and associated costs.

	(fluoroscopy or CT), cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure)		
TOTAL		\$1,436.98	\$0.00

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

1. 28 Texas Administrative Code §133.307, effective May 25, 2008, 33 *Texas Register* 3954, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 set out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 97-Payment is included in the allowance for another service/procedure.
 - MX59-Per NCCI, the procedure code is denied, as included in a more extensive procedure. Procedure included in 64490.
 - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
 - W3-Additional payment made on appeal/reconsideration.
 - P300-The amount paid reflects a fee schedule reduction.
 - M445-Original fee schedule value has been increased according to the state guidelines.
 - Z710-The charge for this procedure exceeds the fee schedule allowance.

Issues

1. Is the allowance of CPT code 20553 included in the allowance of code 64490?
2. Is the requestor entitled to additional reimbursement?

Findings

1. According to the explanation of the respondent denied reimbursement for CPT code 20553 based upon reason codes "97" and "MX59."

28 Texas Administrative Code §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."

On the disputed date of service the requestor billed CPT codes 20553, 64490-50, 64491-50 and 64492-50.

28 Texas Administrative Code §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 payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

Per CCI edits, CPT code 20553 is a component of CPT code 64490; however, a modifier is allowed to differentiate the service. A review of the submitted medical billing finds that the requestor did not appended a modifier to CPT code 20553; therefore, the respondent's denial is supported. As a result, reimbursement is not recommended.

2. According to the submitted explanation of benefits, the respondent issued payment for codes 64490-50, 64491-50, and 64492-50 based upon reason codes "P300" and "Z710."

The requestor appended modifier 50-Bilateral procedure to code 64490, 64491, and 64492.

Per 28 Texas Administrative Code §134.203(c)(1)(2), "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."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

Place of Service is 11-Office Based.

The 2014 DWC conversion factor for this service is 55.75.

The Medicare Conversion Factor is 35.8228

Review of Box 32 on the CMS-1500 the services were rendered in zip code 77042, which is located in Houston, Texas; therefore, the Medicare participating amount is based on locality "Houston Texas".

Using the above formula, the Division finds the following:

Code	Medicare Participating Amount	Maximum Allowable Reimbursement	Carrier Paid	Amount Due
64490-50	\$197.30	\$307.05 X 150% for bilateral procedure = \$460.58	\$460.59	\$0.00
64491-50	\$96.91	\$150.82 X 150% for bilateral procedure = \$226.22	\$226.23	\$0.00
64492-50	\$97.63	\$151.94 X 150% for bilateral procedure = \$227.90	\$227.90	\$0.00

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

08/14/2015
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.