



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

Old Republic Insurance Company

MFDR Tracking Number

M4-18-1613-01

Carrier's Austin Representative

Box Number 44

MFDR Date Received

January 29, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134. The carrier has not responded or denied this claim in its entirety following our filing of Request for Reconsideration."

Amount in Dispute: \$176.14

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: May 18, 2017, 99214, \$176.14, \$176.14

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. Neither party submitted an explanation of benefits regarding the date of service in dispute.

Issues

1. Did the carrier respond to the medical fee dispute?
2. What rule is applicable to reimbursement?

Findings

1. The Austin carrier representative for Old Republic Insurance Co is White Espey PLLC. White Espey PLLC acknowledged receipt of the copy of this medical fee dispute on February 7, 2018. 28 Texas Administrative Code §133.307 states, in relevant part:

(d) Responses. Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division.

1. Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile **within 14 calendar days after the date the respondent received the copy of the requestor's dispute** [emphasis added]. 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.

Review of the documentation finds that no response has been received on behalf of Old Republic Insurance Co from White Espey PLLC to date. The division concludes that Old Republic Insurance Co failed to respond within the timeframe required by §133.307(d)(1). For that reason the division will base its decision on the information available.

2. The requestor is seeking \$176.14 for professional medical services rendered on May 18, 2017. The carrier provided no explanation of benefits or response to this request for MFDR. Therefore, the service in dispute will be reviewed per the applicable Division rules and fee guidelines.

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).

The maximum allowable reimbursement (MAR) is calculated as follows:

$(\text{DWC Conversion Factor} / \text{Medicare Conversion Factor}) \times \text{Medicare allowable or } \$57.5 / \$35.8887 \times \$110.09 = \$176.38.$

Per Rule §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is \$176.14.

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 \$176.14.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor \$176.14, 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

May 4, 2018

Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §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 MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **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.