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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
AHMED KHALIFA, MD

Respondent Name
COMMERCE & INDUSTRY INSURANCE

MFDR Tracking Number
M4-18-4198-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JULY 3, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim is for case management meeting."

Requestor's Supplemental Position Summary: "We show a balance of $259.71."

Amount in Dispute: $259.71

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "After further review of the above referenced medical fee dispute, the Carrier has reimbursement the Provider $92.69 based on a fee schedule adjustment. Payment was issued on July 23, 2018 with check number 33158816."

Response Submitted By: Jennifer Burns for Commerce & Industry Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 10, 2017	CPT Code 99367	$259.71	$0.00

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 §134.220, effective July 7, 2016 sets the reimbursement guidelines for case management/team conferences services in the workers compensation system.
3. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for professional services.
4. 28 Texas Administrative Code §134.1, effective March 1, 2008, provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
5. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines
6. The services in dispute were reduced/denied by the respondent with the following reason code:
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - The charge for the procedure exceeds the amount indicated in the fee schedule.

Issues

1. What is the applicable fee guideline?
2. Did the requestor bill for the case management/team conference services in accordance with the fee guideline?
3. Is the requestor entitled to additional reimbursement for CPT code 99367?

Findings

1. On the disputed date of service, the requestor billed $352.40 for code 99367. CPT code 99367 is defined as "Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician."

   The fee guidelines for case management /team conferences services is found in 28 Texas Administrative Code §134.220.

2. A review of 28 Texas Administrative Code §134.220 lists codes 99361, 99362, 99371, 99372, and 99373 for case management/team conference services in the workers compensation system. The division finds the requestor did not bill for case management/team conference services in accordance with28 Texas Administrative Code §134.220.

3. Since code 99367 is not found in 28 Texas Administrative Code §134.220, the division will refer to 28 Texas Administrative Code §134.203 for professional services.

   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."

   The respondent wrote, "After further review of the above referenced medical fee dispute, the Carrier has reimbursement the Provider $92.69 based on a fee schedule adjustment. Payment was issued on July 23, 2018 with check number 33158816."

   Per Medicare CPT code 99367 is a status "B-Bundled" code; therefore, it is not assigned a relative value.

   Per 28 Texas Administrative Code §134.203(f), "For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement)."

   28 Texas Administrative Code §133.307(c)(2)(O), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable." Review of the submitted documentation finds that the respondent paid $92.69 for CPT code 99367. The division finds the requestor does not demonstrate or justify that the additional amount sought of $259.71 for CPT code 99367 would be a fair and reasonable rate of reimbursement. As a result, additional payment cannot be recommended.

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

		9/26/2018
Signature	Medical Fee Dispute Resolution Officer	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, 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 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.