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
Dr. Ahmed Khalifa

Respondent Name
El Paso County Community Center

MFDR Tracking Number
M4-20-0262-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
September 27, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The EMG portion of the test was incorrectly reduced."

Amount in Dispute: $176.38

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: None submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 7, 2018	Professional medical services	$176.38	$144.48

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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers compensation jurisdiction fee schedule adjustment
   - 97H – The benefit for this service is included in the allowance for another service/procedure that has already been adjudicated.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What rule is applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for professional medical services rendered on December 7, 2018.

   The insurance carrier reduced Code 95886 based on workers compensation fee schedule and denied Codes A4556 and A4215 as being bundled into the primary code.

   Review of the status code for A4556 finds this code is listed as P-Bundled/Excluded Code. The status code for A4215 finds status code X-Statutory Exclusion.

   The insurance carrier's denial for these services is supported. Review of the reduction of code 95886 is found below.

2. 28 TAC 134.203 (c) details for professional services system participants shall apply the Medicare payment policies when determining the maximum allowable reimbursement with minimal modifications.

   The DWC established conversion factor for the date of service in dispute is $58.31 divided by the Medicare conversion factor of $35.9996 multiplied by the Medicare physician fee schedule allowable or 58.31/35.9996 x $89.51 x 2 = $289.97.

3. The total allowable for the service in dispute is $289.97. This insurance company paid $144.52. The requestor is seeking $144.48. This amount is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has established payment is due. As a result, the amount ordered is $144.48.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable) and based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $144.48 plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 11, 2019 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC 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 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.