

## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Ahmed Khalifa

**Respondent Name**

Texas Council Risk Management Fund

**MFDR Tracking Number**

M4-23-1698-01

**Carrier's Austin Representative**

Box Number 43

**DWC Date Received**

March 16, 2023

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 13, 2022	99205	0.00	\$0.00
December 13, 2022	95886	\$572.03	\$12.95
December 13, 2022	95913	\$0.00	\$0.00
<b>Total</b>		\$572.03	\$12.95

### Requestor's Position

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

**Amount in Dispute:** \$572.03

### Respondent's Position

The Austin carrier representative for Texas Council Risk Management Fund is JI Specialty Services Inc. The representative was notified of this medical fee dispute on March 21, 2023.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available

information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

## **Findings and Decision**

### Authority

This medical fee dispute is decided according to [Texas Labor Code §413.031](#) and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

### Statutes and Rules

1. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.
2. [28 TAC §134.203](#) sets out the reimbursement guidelines for professional medical services.

### Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 300 – The charge for this procedure exceeds the fee schedule allowance
- 56 – Significant, separately identifiable E/M service rendered

### Issues

1. Did the insurance carrier pay for the total number of units billed?
2. What rule is specific to reimbursement of disputed services?
3. Is the requestor due additional reimbursement?

### Findings

1. The requestor is seeking medical fee dispute resolution in the amount of \$572.03 for CPT code 95886 rendered December 13, 2022. The respondent reduced the payment amount based on the workers' compensation fee schedule.

Review of the submitted medical claim found the requestor billed for four units. The explanation of benefits indicates only one unit was paid.

DWC Rule 28 TAC §134.203 (b)(1) states in pertinent part for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system

participants shall apply the Medicare payment policies, including its coding; billing; correct coding initiatives, (CCI) edits; modifiers.

Review of the Billing and Coding of Nerve Conductions Studies and Electromyography CMS Article at [www.cms.gov](http://www.cms.gov), found for Code 95886 with indication of pain, numbness or tingling (unilateral) the maximum number of studies is one. DWC will review the fee guideline for one unit of Code 95886 rendered on December 13, 2022.

2. DWC Rule 28 TAC §134.203(c)(1) states, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. For service categories of Evaluation & Management, the established conversion factor to be applies for FY 2022 is 33.59." The maximum allowable reimbursement MAR is calculated by dividing the DWC Conversion Factor by the Medicare Conversion factor and multiplying by the CMS Physician fee schedule for the location.
- DWC Conversion Factor \$62.46
  - CMS Conversion Factor \$33.59
  - Services rendered in Houston, Texas.
  - Carrier and location code 04412/18
  - CMS Physician fee schedule allowable \$100.58
  - $62.46/33.59 \times 100.58 \times 1 = \$204.32$

The total MAR is \$204.32. The insurance carrier paid \$191.37. The remaining balance of \$12.95 is due to the requestor.

### Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has established that additional reimbursement is due.

### **Order**

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Texas Council Risk Management Fund must remit to Ahmed Khalifa \$12.95 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

### **Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

May 25, 2023  
\_\_\_\_\_  
Date

### **Your Right to Appeal**

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at [www.tdi.texas.gov/forms/form20numeric.html](http://www.tdi.texas.gov/forms/form20numeric.html). DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in [28 TAC §141.1\(d\)](#).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).