TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Ahmed Khalifa, M.D.

Respondent Name
Safety National Casualty Corporation

MFDR Tracking Number
M4-23-1713-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
March 16, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 6, 2022	Outpatient Office Visit – New Patient 99203	$209.80	$209.80
	Needle Electromyography 95886	$381.70	$381.70
	Nerve Conduction Studies 95911	$409.80	$409.80
	Total	$1,001.30	$1,001.30

Requestor's Position

Service codes and CPT codes are not to be bundled nor compounded and are to be billed and reimbursed separately and independently from one another.

Amount in Dispute: $1,001.30

Respondent's Position

The Austin carrier representative for Safety National Casualty Corporation is Flahive, Ogden & Latson. 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 (TLC) §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.305 sets out the procedures for resolving medical disputes.

2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

3. 28 TAC §134.203 sets out the fee guidelines for professional medical services.

4. Texas Insurance Code (TIC), Chapter 1305 sets out the requirements for certified health care networks.

Denial Reasons

The insurance carrier denied payment for the disputed services with the following claim adjustment codes:

- 242 – Services not provided by network/primary care prov
- 25 – Separate E&M Service. Same Physician
- NNP – Out-of-network pproval not requested prior to rendering services.
- Notes: "This claim is part of the Corvel Texas Healthcare Network (TXHCN)"

Issues

1. Is Safety National Casualty Corporation's denial based on network status supported?

2. Is Ahmed Khalifa, M.D. entitled to additional reimbursement?

Findings

1. Dr. Khalifa is seeking reimbursement for services performed on October 6, 2022. The insurance carrier denied payment stating that the services were not provided by network or primary care provider.

   Per 28 TAC §§133.305 and 133.307, medical fee dispute resolution by DWC is limited to non-network and certain out-of-network health care. DWC finds that the insurance carrier failed to provide documentation to support that the claim in question was part of a certified health care

network as outlined in the applicable portions of TIC, Chapter 1305.

DWC finds that the insurance carrier's denial of payment based on network status is not supported.

2. Because the insurance carrier failed to support its denial of payment, Dr. Khalifa is entitled to reimbursement for the services in question.

28 TAC §134.203 (b) 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."

Procedure code 95886 has a global indicator of "ZZZ" and is defined as "Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels (List separately in addition to code for primary procedure)."

Procedure code 95911 has a global indicator of "XXX" and is defined as "Nerve conduction studies; 9-10 studies."

Procedure code 99203 has a global indicator of "XXX" and is defined as "Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter."

National Correct Coding Initiative Policy Manual, effective May 1, 2022, Chapter U, Evaluation and Management Services, Section 6, states, in relevant part:

""Medicare Global Surgery Rules define the rules for reporting E&M services with procedures covered by these rules …

"The global concept does not apply to XXX procedures … All procedures with a global period of ZZZ are related to another procedure, and the applicable global period for the ZZZ code is determined by the related procedure …

"Procedures with a global surgery indicator of 'XXX' are not covered by these rules. Many of these 'XXX' procedures are performed by physicians and have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work shall not be reported as a separate E&M code. Other 'XXX' procedures are not usually performed by a physician and have no physician work relative value units associated with them. A provider/supplier shall not report a separate E&M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure.

With most 'XXX' procedures, the physician may, however, perform a significant and separately identifiable E&M service that is above and beyond the usual pre- and post-operative work of the procedure on the same date of service which may be reported by appending modifier 25 to the E&M code. This E&M service may be related to the same diagnosis necessitating performance of the 'XXX' procedure but cannot include any work inherent in the "XXX" procedure, supervision of others performing the 'XXX' procedure, or time for interpreting the result of the 'XXX' procedure."

Dr. Khalifa billed procedure code 99203 with modifier 25 defined as a "Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service."

This modifier may be used "to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported … The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service …"

Per 28 TAC §134.203 (c), "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 …

(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 …"

To determine the MAR, the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) x Medicare Participating Amount.

- The DWC conversion factor for 2022 is 62.46.
- The Medicare conversion factor for 2022 is 34.6062.
- Per the submitted medical bills, the service was rendered in zip code 77042 which is in Medicare locality 0441218.

The Medicare participating amount for CPT code 99203 is $116.56. The MAR is calculated as

follows: (62.46/34.6062) x $116.56 = $210.38 for the first unit. Dr. Khalifa is seeking $209.80. This amount is recommended.

The Medicare participating amount for CPT code 95886 is $106.03. The MAR is calculated as follows: (62.46/34.6062) x $106.03 = $191.37 x 2 units = $382.74. Dr. Khalifa is seeking $381.70. This amount is recommended.

The Medicare participating amount for CPT code 95911 is $227.67. The MAR is calculated as follows: (62.46/34.6062) x $227.67 = $410.92. Dr. Khalifa is seeking $409.80. This amount is recommended.

The total allowable reimbursement for the services in question is $1,001.30. This amount is recommended.

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 requestor has established that additional reimbursement of $1,001.30 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that Safety National Casualty Corporation must remit to Ahmed Khalifa, M.D. $1,001.30 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		June 7, 2023
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 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. 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 three or email 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 tres o correo electronico CompConnection@tdi.texas.gov.