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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
AHMED KHALIFA MD

Respondent Name
MID-CENTURY INSURANCE CO

MFDR Tracking Number
M4-10-5338-01

Carrier's Austin Representative
Box Number 14

MFDR Date Received
AUGUST 30, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "THE CLAIM IS FOR DIAGNOSTIC TESTING THAT WAS REFERRED BY THE DESIGNAED DOCTOR. PER THE ABOVE RULES AND REGULATIONS-NO PREAUTHORIZATION IS REQUIRED."

Amount in Dispute: $153.75

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 15, 2010	CPT Code 99242	$128.75	$0.00
	CPT Code 99070	$25.00	$0.00
TOTAL		$153.75	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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, effective March 1, 2008, *33 Texas Register 364*, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 226-Information requested from the billing/rendering provider was not provided or was insufficient/incomplete.
   - 245-Payment pending receipt of invoice.
   - 612-No payment is made as Medicare uses another code for reporting and/or payment of this service.

- 97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

Issues

1. Does the documentation support billing of CPT code 99242?
2. Is the value of CPT code 99070 included in the value of another service rendered on the disputed date?

Findings

1. CPT code 99242 is defined as "Office consultation for a new or established patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 30 minutes are spent face-to-face with the patient and/or family."

   According to the explanation of benefits, the respondent denied reimbursement for code 99242 based upon reason code "612-No payment is made as Medicare uses another code for reporting and/or payment of this service."

   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 Medicare billing policy applicable to the disputed service can be found at www.cms.gov in the CMS Manual System Pub 100-04 Medicare Claims Processing, Transmittal 1875, Change Request (CR) 6740, dated December 14, 2009, effective January 1, 2010. CR#6740 states that the use of all consultation codes (ranges 99241-99245 and 99251-99255) was eliminated effective January 1, 2010. In lieu of consultation codes, participants were directed to use codes 99201-99205 that identify the complexity of the visit performed. The eliminated codes include 99244 which the requestor reported on its medical bills.

   The division concludes that the requestor failed to code the office consultation in dispute in accordance with the applicable Medicare policy in effect on the date the service in dispute was provided, thereby failing to meet the correct coding requirements of §133.20(c), and §134.203 (b)(1). For that reason, no reimbursement can be recommended.

2. CPT Code 99070 is defined as "Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)."

   The respondent denied reimbursement for CPT code 99070 based upon reason codes "245-Payment pending receipt of invoice," and "97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated."

   The Division reviewed the submitted documentation and finds that the requestor does not identify the supplies or materials in dispute. Because the services are not identified, the Division is unable to determine if the value of the supplies/materials are included in the value of another procedure performed on the disputed date. Therefore, reimbursement 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

		04/0/4/2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing 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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

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