TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Edwin Johnstone MD

Respondent Name
Great West Casualty Co

MFDR Tracking Number
M4-17-2032-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
March 3, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am requesting full payment for this claim."

Amount in Dispute: $500.00

RESPONDENT'S POSITION SUMMARY

The Austin carrier representative for Great West Casualty Co is JT Parker & Associates. JT Parker & Associates acknowledged receipt of the copy of this medical fee dispute on March 13, 2017.

28 Texas Administrative Code §133.307(d)(1) states:

> Responses. Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division.
>
> (1) Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile **within 14 calendar days after the date the respondent received the copy of the requestor's dispute**. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

Review of the documentation finds that no response has been received from JT Parker & Associates to date. The Division concludes that the carrier failed to respond within the timeframe required by §133.307(d)(1). For that reason the Division will base its decision on the information available.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 14, 2016	99245	$500.00	$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 §134.203 sets out the reimbursement guidelines for professional medical services.
3. 28 Texas Administrative Code §129.5 sets out procedures for filing work status reports.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 226 – Information requested from the billing/rendering provider was not provided or not provided timely or was insufficient/incomplete
   - P12 – Workers compensation jurisdictional fee schedule adjustment
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

1. The requestor is seeking reimbursement for professional medical services in the amount of $500.00 rendered on December 14, 2016. The insurance carrier denied the following disputed service with remark code 226 – "Information requested from the billing/rendering provider was not provided or not provided timely or was insufficient/incomplete."

   - Code 99245 – "Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. 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 moderate to high severity. Typically, 80 minutes are spent face-to-face with the patient and/or family"

   As these are professional medical services, the disputed services are subject to the provisions of 28 Texas Administrative Code §134.203 (a) (5) and (b) (1) which states in pertinent parts,

   > 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.
   >
   > (b) 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;

   Review of the applicable Medicare payment policy regarding Code 99245 finds the following;

   Medicare Med Learn Matters Article at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm6740.pdf states the following;

   > *Effective January 1, 2010, the Current Procedural Terminology (CPT) consultation codes (ranges 99241-99245 and 99251-99255) are no longer recognized for Medicare Part B payment. Effective for services furnished on or after January 1, 2010, providers should code a patient evaluation and management visit with E/M codes that represents* ***WHERE*** *the visit occurs and that identify the* ***COMPLEXITY*** *of the visit performed. See the Key Points section of this article for details.*

   As the date of service in dispute is December 14, 2016, which is after this notification, Code 99245 is not a recognized consultation code. The carrier's denial is supported. No additional payment is 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 on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		June 9, 2017
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 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 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. **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.