

## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

AHMED KHALIFA

**Respondent Name**

SAFETY NATIONAL CASUALTY

**MFDR Tracking Number**

M4-21-2452-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

August 27, 2021

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 27, 2021	CPT Code 99204-25	\$304.66	\$0.00
	CPT Code 95886	\$0.00	\$0.00
	CPT Code 95910	\$0.00	\$0.00
<b>Total</b>		\$304.66	\$0.00

### Requestor's Position

"We are providing supporting documentation specifically explaining and outlining our position in accordance with Rule 133 and 134 governing bills/claims submitted in reference to workers compensation treatment and services."

**Amount in Dispute:** \$304.66

## **Respondent's Position**

The Austin carrier representative for Flahive Ogden & Latson is Safety National Casualty Corp. The representative was notified of this medical fee dispute on September 08, 2021.

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, effective March 1, 2008, sets out the reimbursement guidelines for the disputed service.

### Denial Reasons

The insurance carrier [reduced or denied] the payment for the disputed services with the following claim adjustment codes:

- 90168 – Payment adjusted because the payer deems the information submitted does not support this level of service
- 150 -Payment adjusted because the payer deems the information submitted does not support this level of service
- P12 – Workers Compensation Jurisdictional fee schedule adjustment
- 5352 – CV, Service reduced/denied as Level of E&M Code submitted is not supported by documentation

### Issues

1. Is Ahmed Khalifa entitled to reimbursement?

### Findings

1. The requestor is seeking medical fee dispute resolution in the amount of \$304.66 for CPT Code 99204-25 rendered on May 27, 2021.

The fee guidelines for disputed services are found in 28 TAC §134.203.

28 TAC §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."

CPT code 99204 is described 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 moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter."

The requestor appended modifier "25- 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."

Modifier "25" is defined as "It may be necessary 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 (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). 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."

The respondent denied reimbursement for CPT code 99204-25 as Payment adjusted because the payer deems the information submitted does not support this level of service and – CV, Service reduced/denied as Level of E&M Code submitted is not supported by documentation. Review of the submitted medical record found time in to be 2:20 pm and out time 3:40 pm. However, also during this time record indicates EMG/NCV testing also done. Insufficient evidence was found to support how much time was spent conducting the consultation from the testing. The respondent's denial is supported. As a result, reimbursement is not 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 requester has not established that additional reimbursement is due.

**Order**

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

### Authorized Signature

[Redacted Signature]

Signature

[Redacted Name]

Medical Fee Dispute Resolution Officer

November 19, 2021

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).