**`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**
ALLSION WALLS PHD

**Respondent Name**
AMERISURE PARTNERS INSURANCE CO

**MFDR Tracking Number**
M4-18-5207-01

**Carrier's Austin Representative**
Box Number 47

**MFDR Date Received**
AUGUST 27, 2018

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134…**DESIGNATED DOCTOR REFERRED TESTING**."

**Amount in Dispute:** $213.79

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The dispute of CPT Code 96116 has not been billed by the HCP. A change of CPT codes would constitute a 'new' billing and be subject to timely filing RULE 133.20. No additional is due to this health care provider. Furthermore, this claim subscribed to the Texas First Health Network and is, therefore, not subject to the Medical Fee Dispute Resolution Process."

**Response Submitted by:** CareWorks Managed Care Services

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| June 14, 2018 | CPT Code 96118 (X22) Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report | $0.00 | $0.00 |
| | CPT Code 96116 Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report | $213.79 | $0.00 |
| TOTAL | | $213.79 | $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 effective May 31, 2012 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system.
3. Neither party to the dispute submitted any explanation of benefits for CPT code 96116.

**Issues**

Is CPT code 96116 eligible for medical fee dispute resolution?

**Findings**

The requestor is seeking medical fee dispute resolution for $213.79 for CPT code 96116 rendered on June 14, 2018.

To determine if the requestor's medical fee dispute is eligible for review the division refers to the following statute:

- 28 Texas Administrative Code §133.240(a) states "An insurance carrier shall take final action after conducting bill review on a complete medical bill or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill. An insurance carrier's deadline to make or deny payment on a bill is not extended because of a pending request for additional documentation."
- 28 Texas Administrative Code §133.250(d) states "A written request for reconsideration shall: (1) reference the original bill and include the same billing codes, date(s) of service, and dollar amounts as the original bill."
- 28 Texas Administrative Code §133.307(c)(2)(J) requires the requestor to submit "a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier in accordance with this chapter and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250 of this chapter (relating to General Medical Provisions)."
- 28 Texas Administrative Code §133.250(i) states "If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill after reconsideration, the health care provider may request medical dispute resolution in accordance with the provisions of Chapter 133, Subchapter D of this title (relating to Dispute of Medical Bills)."
- 28 Texas Administrative Code §133.307(c)(2) requires requests for medical fee dispute resolution to submit:

  "(D) the date(s) of the service(s) in dispute;

  (J) a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier in accordance with this chapter and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250 of this chapter (relating to General Medical Provisions);

  (K) a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB; and

  (M) a copy of all applicable medical records related to the dates of service in dispute."

The findings based upon above referenced statute and submitted documentation are:

- The dispute was not submitted in the form and manner required by 28 Texas Administrative Code §133.307 because there were no bills, explanation of benefits, request for reconsideration or medical records for CPT code 96116 rendered on June 14, 2018.

- CPT code 96116 is not eligible for review because no proof it was ever billed to the insurance carrier per §133.240 and 133.250.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that 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**

| | | |
|---|---|---|
| | | 9/20/2018 |
| 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 28 Texas Administrative Code §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 MDR decision shall deliver a copy of the request 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 §141.1(d).

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