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

AMENDED MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
GABRIEL JASSO PHD

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number
M4-19-0211-02

Carrier's Austin Representative
Box Number 45

MFDR Date Received
SEPTEMBER 17, 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**."

Requestor's Supplemental Position Summary dated November 16, 2018: "No payment received for this one."

Requestor's Supplemental Position Summary dated January 11, 2019: "We have not received payment on this one."

Requestor's Supplemental Position Summary dated January 14, 2019: "There is a balance of $161.45."

Amount in Dispute: $161.45

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Upon notification of this dispute the Office researched the medical billing received from Gabriel Jasso PHD, which determined that payment will be allowed."

Respondent's Supplemental Position Summary dated January 14, 2019: "Please see attached the warrant and the payment EOB supporting payment had been previously paid in full for the charges the requested listed on the DWC 60 for this case. I can't allow an additional payment for CPT 96116 as requested as its been previously paid in full."

Response Submitted by: SORM

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 19, 2018	CPT Code 96118 (X20)	$0.06	$0.00
	CPT Code 96116 (X2)	$161.39	$0.00
TOTAL		$161.45	$0.00

FINDINGS AND DECISION

This **amended** findings and decision supersedes all previous decisions rendered in this medical payment dispute involving the above requestor and respondent.

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 medical fee disputes.
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. The services in dispute were reduced / denied by the respondent with the following claim adjustment reason codes:
   - 309-The charge for this procedure exceeds the fee schedule allowance.
   - 600-Allowance based on maximum number of units allowed per fee schedule guidelines and/or service code description.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - W3-Additional payment made on appeal/reconsideration.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 1014-The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
4. Dispute M4-19-0211-01was originally decided on January 17, 2019 and subsequently withdrawn by the division. As a result of the withdrawal, the dispute was re-docketed at medical fee dispute resolution and is hereby reviewed.

Issues

1. What are the amounts in dispute?
2. Is the requestor entitled to additional reimbursement for CPT codes 96118 (X20) and 96116 (X2)?

Findings

1. 28 Texas Administrative Code §133.307(c)(2), states,

   The requestor shall provide the following information and records with the request for MFDR in the form and manner prescribed by the division. The provider shall file the request with the MFDR Section by any mail service or personal delivery. The request shall include:

   (F) the treatment or service code(s) in dispute;

   (G) the amount billed by the health care provider for the treatment(s) or service(s) in dispute;

   (H) the amount paid by the workers' compensation insurance carrier for the treatment(s) or service(s) in dispute;

   (I) the disputed amount for each treatment or service in dispute.

The division reviewed the submitted documentation and finds:

- Per the *Table of Disputed Services* the requestor billed CPT code 96118 in the amount of $3,216.40 and was paid $3,216.34, for a total disputed amount of $0.06.
- Per the *Table of Disputed Services* the requestor billed CPT code 96116 in the amount of $310.40 and was paid $149.01, for a total disputed amount of $161.39.
- According to the explanation of benefits, the requestor billed CPT code 96118 in the amount of $3,216.40 and was paid $3,055.01.
- According to the explanation of benefits, the requestor billed CPT code 96116 in the amount of $310.40 and was paid $310.34.
- The division finds the requestor incorrectly noted the amount of payment for both codes.

2. The fee guidelines for disputed services are found in 28 Texas Administrative Code §134.203.

On the disputed date of service, the requestor billed CPT codes 96118 (X20) and 96116 (X2).

The respondent wrote, "Please see attached the warrant and the payment EOB supporting payment had been previously paid in full for the charges the requested listed on the DWC 60 for this case. I can't allow an additional payment for CPT 96116 as requested as its been previously paid in full."

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."

28 Texas Administrative Code §134.203 (b)(1) 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."

The disputed services are defined as:

- CPT code 96118 is defined as "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."
- CPT code 96116 is defined as "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."

Per 28 Texas Administrative Code §134.203(c)(1)(2), "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. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

(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. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2018 DWC conversion factor for this service 58.31.

The Medicare Conversion Factor is 35.9996.

Review of Box 32 on the CMS-1500 the services were rendered in zip code 75230 which is located in Dallas, Texas; therefore, the Medicare carrier locality is "Dallas, Texas".

The Medicare Participating amount for code 96118 is $99.27 and $95.80 for code 96116.

Using the above formula, the division finds per the explanation of benefits the requestor was paid the total allowable for CPT code 96116 of $310.34 and $3,055.01 for code 96118.

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

Signature	Medical Fee Dispute Resolution Officer	2/7/2019 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.