



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

GABRIEL JASSO PHD

Respondent Name

INDEMNITY INSURANCE CO OF NORTH AMERICA

MFDR Tracking Number

M4-19-0367-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

SEPTEMBER 24, 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: \$1,705.46

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It has been determined that ESIS Med Bill Impact will stand on the original recommendation of \$2,131.74. Fee schedule for CPT code 96118 is \$160.79 X 20 units equals \$3,215.80. Fee schedule for CPT 96116 is \$155.17 X 4 units equals \$620.68. The provider was reimbursed \$3,836.48 prior to Coventry's reduction of \$1,704.74."

Response Submitted by: ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 12, 2018	CPT Code 96118 (X20)	\$1,428.60	\$0.00
	CPT Code 96116 (X4)	\$275.92	\$0.00
TOTAL		\$1,705.46	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 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 reason code:
- 222-Charge exceeds Fee Schedule allowance.
 - 45-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
 - ETBR-A technical Bill Review (TBR) has been performed.
 - The charges have been priced in accordance to a Coventry owned contract.

Issues

Is the requestor entitled to additional reimbursement for CPT codes 96118 (X20) and 96116 (X4)?

Findings

On the disputed date of service, the requestor billed CPT codes 96118 (X20) and 96116 (X4).

The respondent wrote, "It has been determined that ESIS Med Bill Impact will stand on the original recommendation of \$2,131.74. Fee schedule for CPT code 96118 is \$160.79 X 20 units equals \$3,215.80. Fee schedule for CPT 96116 is \$155.17 X 4 units equals \$620.68. The provider was reimbursed \$3,836.48 prior to Coventry's reduction of \$1,704.74."

A review of the explanation of benefits finds the respondent took a \$1,704 PPO reduction. Neither party submitted any documentation to support a PPO contract exists between the parties; therefore, the disputed services will be reviewed per the fee guideline.

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."

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."

The code descriptor for both codes indicate that they are billed and reported per hour. The requestor billed four (4) hours of code 96116 and twenty (20) hours of code 96118 for a total of twenty-four (24) hours. The division finds the requestor billed for 11 hours of face-to-face time with the claimant for testing and examination on the disputed date of service. The medical records do not support the 11 hours of face-to-face time to support billing. The documentation also does not support 24 hours of services billed on the disputed date. As a result, reimbursement is not 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 services in dispute.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

11/20/2018
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.