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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
GABRIEL JASSO PHD

Respondent Name
DALLAS COUNTY

MFDR Tracking Number
M4-19-4343-01

Carrier's Austin Representative
Box Number 43

MFDR Date Received
June 4, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Incorrect reduction of designated doctor referred testing claim."

Amount in Dispute: $335.03

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: No response was received

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
January 10, 2019	96133	$335.03	$335.03

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, effective March 1, 2008, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - R51B – The procedure does not fall within the Medicare multiple procedure guidelines. Therefore, recommended payment is based on 100% of the allowed amount for the procedure billed or the billed amount, whichever is less
   - W3 – Reporting purposes only
   - 193 – Original payment decision is being maintained. Upon review it was determined that his claim was processed properly.

Issue(s)

1. Did the insurance carrier respond to the medical fee dispute?
2. Were the disputed services referred by the Designated Doctor?
3. Did the requestor submit documentation to support the billing of CPT Code 96133?
4. What is the applicable rule for determining reimbursement for the disputed services?
5. Is the requestor entitled to additional reimbursement?

Findings

1. The Austin carrier representative for Dallas County is York Risk Services Group. York Risk Services Group acknowledged receipt of the copy of this medical fee dispute on June 11, 2019. 28 Texas Administrative Code §133.307(d)(1) states that if the division does not receive the response within 14-calendar days of the dispute notification, then the division may base its decision on the available information.

   As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under 28 Texas Administrative Code §133.307(d)(1).

2. 28 Texas Administrative Code §127.10(c) states, "The designated doctor shall perform additional testing when necessary to resolve the issue in question. The designated doctor shall also refer an injured employee to other health care providers when the referral is necessary to resolve the issue in question and the designated doctor is not qualified to fully resolve the issue in question. Any additional testing or referral required for the evaluation is not subject to preauthorization requirements nor shall those services be denied retrospectively based on medical necessity, extent of injury, or compensability."

   Based upon the submitted documentation, the claimant was referred to the requestor by the Designated Edward W. Smith, D.O., as part of the Designated Doctor examination process.

3. 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."

   On the disputed date of service, the requestor billed CPT code 96133 x 9 units. The CPT Code description of 96133 is "Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure)."

   The lay description of CPT Code 96133 is defined as "The physician or other qualified health care provider performs a neuropsychological testing evaluation and administers a series of tests in thinking, reasoning, judgment, and memory to evaluate the patient's neurocognitive abilities. Code **96132** describes the examination component, including combining data from different sources, interpreting test results and clinical data, decision-making, providing a plan of treatment report, as well as providing interactive feedback with the patient and family members or caregivers for the first hour; report **96133** for each additional hour thereafter. Report **96136** for the initial **30** minutes of time by a physician or other qualified health care professional administering two or more tests to the patient by any method, as well as scoring of the tests; report **96137** for each additional **30** minutes. When a technician performs the test administration and scoring, report **96138** for the initial **30** minutes and **96139** for each subsequent **30**-minute time period. In **96146**, the test is administered via a computer providing an automated result, which is interpreted and reported by a qualified health care professional."

   The requestor billed CPT Code 96133 x 9 units to indicate that an additional 9 hours were rendered on January 10, 2019. The insurance carrier issued payments in the amount of $1,180.21 for 7 hours. The requestor seeks payment for the additional 2 hours.

   A review of the medical records supports the documentation of 10 hours of Neuropsychological testing evaluation services. As a result, reimbursement is determined per 28 Texas Administrative Code §134.203(c)(1)(2).

4. 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."

   Procedure code 96133, January 10, 2019, has a Work RVU of 1.96 multiplied by the Work GPCI of 1.012 is 1.98352. The practice expense RVU of 0.8 multiplied by the PE GPCI of 1.014 is 0.8112. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.768 is 0.05376. The sum is 2.84848 multiplied by the DWC conversion factor of $59.19 for a MAR of $168.60 at 9 units is $1,517.40. Per Rule §134.203(h), reimbursement is the lesser of the MAR or the provider's charge. The lesser amount is $1,515.24. The insurance carrier issued a payment in the amount of $1,180.21, as a result the requestor is entitled to an additional payment in the amount of $335.03. Therefore, this amount is recommended.

5. Review of the submitted documentation finds that the requestor is entitled to an additional $335.03. Therefore, this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $335.03.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $335.03 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		August 23, 2019
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, 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 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.