



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

ALLISON WALLS, PHD

Respondent Name

INDEMNITY INSURANCE CO OF NORTH AMERICA

MFDR Tracking Number

M4-19-4352-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

JUNE 3, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has reduced this claim inappropriately and not in accordance and compliance with TDI-DWC Rule 133 and 134."

Amount in Dispute: \$153.43

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Bill has been reviewed and denial stands as the provider billed CPT 90791 together with 96116; payment for 90791 was issued. Denial for 96116: Per NCCI, the procedure code is denied, as per the CPT manual or CMS manual coding instructions. Procedure included in 90791."

Response Submitted by: Helmsman Management Services LLC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 30, 2018	CPT Code 96118 (X22)	\$0.00	\$0.00
	CPT Code 96116	\$153.43	\$0.00
	CPT Code 90791	\$0.00	\$0.00
TOTAL		\$153.43	\$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, effective May 31, 2012, 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 claim adjustment reason codes:
- 97-The benefit for this service is included in the payment allowance for another service/procedure that has already been adjudicated.
 - 906-In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code Editor) component code of comprehensive medicine, Evaluation and Management services procedure (90000-99999) has been disallowed.

Issues

Is the allowance of code 96116 included in the allowance of code 90791? Is the requestor entitled to reimbursement?

Findings

1. The fee guidelines for disputed services are found at 28 Texas Administrative Code §134.203.
2. On the disputed date of service, the requestor billed CPT codes 96118 (X22), 90791 and 96116. Only code 96116 is in dispute.
3. According to the explanation of benefits, the respondent denied payment for code 96116 based upon “97-The benefit for this service is included in the payment allowance for another service/procedure that has already been adjudicated,” and “906-In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code Editor) component code of comprehensive medicine, Evaluation and Management services procedure (90000-99999) has been disallowed.”
4. 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.”
5. 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.”
6. 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 requestor appended modifier -59 to code 96116.
7. Per CCI edits, CPT code 96116 is included in the allowance of code 90791, and a modifier is not allowed to differentiate the service.
8. The division finds the respondent’s denial based upon reason codes “97” and “906” is supported. 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 disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

6/13/2019
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.