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
SENTRY CASUALTY CO

MFDR Tracking Number
M4-20-0535-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
OCTOBER 24, 2019

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: $160.29

RESPONDENT'S POSITION SUMMARY

"We have verified that this bill paid correctly according to the Texas Fee Schedule."

Response Submitted by: Sentry Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 25, 2019	CPT Code 90791 (X1)	$0.00	$0.00
	CPT Code 96116-25 (X1)	$160.29	$0.00
	CPT Code 96130 (X1)	$0.00	$0.00
	CPT Code 96131 (X7)	$0.00	$0.00
	CPT Code 96136(X1)	$0.00	$0.00
	CPT Code 96137 (X3)	$0.00	$0.00
TOTAL		$160.29	$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 (DWC).

Background

1. 28 Texas Administrative Code (TAC) §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:
   - 435-Per NCCI Edits, the value of this procedure is included in the value of the comprehensive procedure.
   - 236-This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the NCCI or workers compensation state regulations/fee schedule requirements.
   - 350-Bill has been identified as a request for reconsideration or appeal.
   - W3-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

Is the allowance of code 96116-25 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 TAC §134.203.
2. On the disputed date of service, the requestor billed CPT codes 90791, 96116-25, 96130, 96131, 96136, and 96137. Only code 96116-25 is in dispute.
3. According to the explanation of benefits, the respondent denied payment for code 96116-25 based upon "435-Per NCCI Edits, the value of this procedure is included in the value of the comprehensive procedure; and 236-This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the NCCI or workers compensation state regulations/fee schedule requirements."
4. 28 TAC §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 TAC §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 DWC finds the respondent's denial based upon reason codes "435" and "236" is supported. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the DWC 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 DWC has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		11/06/2019
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, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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 DWC. **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.