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
NORTH TEXAS PAIN RECOVERY CENTER

Respondent Name
HARTFORD INSURANCE COMPANY OF MIDWEST

MFDR Tracking Number
M4-20-1104-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
DECEMBER 31, 2019

REQUESTOR'S POSITION SUMMARY

A position summary was not submitted.

Amount in Dispute: $490.00

RESPONDENT'S POSITION SUMMARY

"The Hartford requested additional information as furnished medical records were not conclusive of the level of care provided. CPT codes billed are time-based codes and require time notation in the documentation for payment."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 6, 2019	CPT Code 96130 (X1)	$200.00	$0.00
	CPT Code 96131 (X1)	$150.00	$0.00
	CPT Code 96138(X1)	$70.00	$0.00
	CPT Code 96139 (X1)	$70.00	$0.00
TOTAL		$490.00	$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:
    - 16-Claim/service lacks information which is needed for adjudication. Additional information is supplies using remittance advice remarks codes whenever appropriate.
    - 267-An itemized billing of the time spent performing this service is needed for further review.
    - 18-Exact duplicate claim/service.
    - 247-A payment or denial has already been recommended for this service.
    - DPL2-This submission is being processed as a duplicate as the original bill is still in review.

Issues

Does the documentation support billed services? Is the requestor entitled to reimbursement?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $490.00 for CPT codes 96130, 96131, 96138, and 96139.
2. The respondent denied reimbursement for the disputed services based upon claim adjustment reason codes: "16-Claim/service lacks information which is needed for adjudication. Additional information is supplies using remittance advice remarks codes whenever appropriate;" and "267-An itemized billing of the time spent performing this service is needed for further review."
3. The fee guidelines for disputed services are found at 28 TAC §134.203.
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. The disputed services are described as:
    - 96130-Psychological 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; first hour.
    - 96131-Psychological 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).
    - 96138-Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes.
    - 96139-Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure).
7. The disputed codes are timed based procedures. The requestor's report does not list start and end times, or list the amount time spent performing each procedure. The DWC finds the respondent's denial based upon reason codes "16" and "267" 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 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

		1/23/2020
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.