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
GREAT WEST CASUALTY CO

MFDR Tracking Number
M4-21-0236-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
OCTOBER 13, 2020

REQUESTOR'S POSITION SUMMARY

"DESIGNATED DOCTOR REFERRED TESTING…OUR CONFIRMATIONS TO THE FAX NUMBER LISTED IN THE ATTACHED DWC 32 ARE ATTACHED…The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134."

Amount in Dispute: $3,811.32

RESPONDENT'S POSITION SUMMARY

"The bill was denied on the basis that it was not timely submitted to the carrier."

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 6, 2019	CPT Code 96116 (X1) Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour	$161.97	$161.97
	CPT Code 96121 (X3) Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour (List separately in addition to code for primary procedure)	$417.66	$417.66

	CPT Code 96132 (X1) 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; first hour	$222.71	$0.00
	CPT Code 96133 (X9) 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)	$1,529.01	$0.00
	CPT Code 96136(X1) Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes	$79.67	$0.00
	CPT Code 96137 (X19) Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)	$1,400.30	$0.00
TOTAL		$3,811.32	$579.63

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. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
3. Texas Labor Code §408.0272, effective September 1, 2007, provides for exceptions for timely submission of a claim by a health care provider.
4. 28 TAC §133.20, effective January 29, 2009, sets out the health care providers billing procedures.
5. 28 Texas Administrative Code §102.4(h), effective May 1, 2005, sets out rules to determine when written documentation was sent.
6. 28 TAC §134.203, effective March 1, 2008, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system.
7. 28 TAC §127.10 effective September 1, 2012, sets out the Designated Doctor procedures and requirements.
8. The services in dispute were reduced / denied by the respondent with the following claim adjustment reason codes:
   - 29-The time limit for filing has expired.
   - 4271-Per TX Labor code sec 413.016, Providers must submit bills to payors within 95 days of the date of service.

Issues

Is the requestor entitled to reimbursement for professional services rendered on December 6, 2019?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $3,811.32 for CPT codes 96116, 96121, 96132, 96133, 96136, and 96137 rendered on December 6, 2019.
2. The respondent denied reimbursement for the disputed services based upon timely filing.
3. To determine if the disputed professional services are eligible for reimbursement the DWC refers to the following statute:
   - Texas Labor Code §408.027(a) states, "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."
   - Texas Labor Code §408.0272(b)(1) states "Notwithstanding Section 408.027, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.027(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if: (1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with: (A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured; (B) a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee; or (C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title."
   - 28 TAC §133.20(B) states, "Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided. In accordance with subsection (c) of the statute, the health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill. A health care provider who submits a medical bill to the correct workers' compensation insurance carrier shall include a copy of the original medical bill submitted, a copy of the explanation of benefits (EOB) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied. The medical bill submitted by the health care provider to the correct workers' compensation insurance carrier is subject to the billing, review, and dispute processes established by Chapter 133, including §133.307(c)(2)(A) - (H) of this title (relating to MDR of Fee Disputes), which establishes the generally acceptable standards for documentation."
   - 28 TAC §102.4(h), states, "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."
4. Both parties to this dispute submitted documentation for consideration in support of their position. The DWC reviewed the documentation and finds:
   - The date of service in dispute is December 6, 2019.
   - The requestor submitted a medical bill with a facsimile transmission verification report that supports a claim was submitted to respondent on December 23, 2019 and February 21, 2020.
   - The requestor submitted evidence such as a fax transmission reports to support the bill was sent to the respondent within the 95 day deadline.
   - The requestor sufficiently supported position that the claim was submitted to the respondent within the 95 day deadline set out in Texas Labor Code §408.027(a) and 28 TAC §133.20(B).
   - The respondent's denial of payment based upon timely filing is not supported.
5. The DWC refers to the following statutes to determine the appropriate reimbursement:
   - The fee guideline for disputed services is found at 28 TAC§134.203.
   - 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."

- 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. On the disputed date of service, the requestor billed CPT codes 96116, 96121, 96132, 96133, 96136 and 96137.

   NCCI Policy Manual, Chapter 11, (M)(2), effective January 1, 2019 states, "The psychiatric diagnostic interview examination (CPT codes 90791, 90792), psychological/neuropsychological testing (CPT codes 96136-96146), and psychological / neuropsychological evaluation services (CPT codes 96130-96133) must be distinct services if reported on the same date of service. CPT Manual instructions permit physicians to integrate other sources of clinical data into the report that is generated for CPT codes 96130-96133. Since the procedures described by CPT codes 96130-96139 are timed procedures, physicians shall not report time for duplicating information (collection or interpretation) included in the psychiatric diagnostic interview examination and/or psychological/neuropsychological evaluation services or test administration and scoring. (CPT codes 96101 and 96118 were deleted January 1, 2019.)

   The requestor noted on the Psychological Evaluation Report that the claimant underwent a total of 24 hours of examination and testing on the disputed date of service. The report noted that the claimant underwent Neuropsychological testing evaluation services: 10 hours; Examinee Interview & Neurobehavioral/Mental Status Exam: 4 hour; Neuropsychological Testing and Scoring: 10 hours.

   The DWC finds the requestor did not bill in accordance with NCCI Policy Manual, Chapter 11, (M)(2), because "procedures described by CPT codes 96130-96139 are timed procedures, physicians shall not report time for duplicating information (collection or interpretation) included in the psychiatric diagnostic interview examination and/or psychological/neuropsychological evaluation services or test administration and scoring." The report does not list the start and end time of time procedure codes 96132, 96133, 96136 and 96137 to support the number of hours billed; therefore, reimbursement cannot be recommended.

   28 TAC §134.203(c)(1) states "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."

   28 TAC §134.203(c)(2) states "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. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   The DWC conversion factor for 2019 is 60.32.

   The Medicare conversion factor for 2019 is 36.0896.

   The locality is Houston, Texas

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = Maximum Allowable Reimbursement (MAR).

   Using the above formula, the MAR is:

Code	Medicare Participating Amount	Number of Units	MAR	Insurance Carrier Paid	Amount Due
96116	$98.76	1	$162.01 or lesser amount	$161.97 (Amount Billed)	$161.97
96121	$84.89	3	$139.42 or lesser amount	$417.66 (Amount Billed)	$417.66

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $579.63.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services.
The division hereby ORDERS the respondent to remit to the requestor $579.63, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	11/10/2020 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.