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
BOB L.GANT, PHD

Respondent Name
CALIFORNIA INSURANCE CORP

MFDR Tracking Number
M4-21-1177-01

Carrier's Austin Representative
Box Number 12

MFDR Date Received
MARCH 11, 2021

REQUESTOR'S POSITION SUMMARY

"Attached is a completed CMS 1500 claim form along with the completed Neuropsychological Evaluation report. The form and narrative report resulted from a referral by a Designated Doctor in the course of conducting a state ordered Designated Doctor Examination."

Amount in Dispute: $1,949.74

RESPONDENT'S POSITION SUMMARY

"In this case, the Carrier reduced payment for the billed expenses because: (1) the charge exceeded the fee schedule allowance, and (2) Provider failed to identify the time spent to perform services."

Response Submitted By: California Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 27, 2020	CPT Code 96121 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)	$400.00	$0.00
	CPT Code 96133 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)	$1,399.52	$0.00

	CPT Code 96137 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)	$150.22	$0.00
TOTAL		$1,949.74	$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. The services in dispute were reduced / denied payment by the respondent with the following claim adjustment reason codes:
   - 222-Charge exceeds Fee Schedule allowance.
   - A232, W3-Additional payment made on appeal/reconsideration.
   - A43-Documentation does not support quantities billed.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 256-Identify time spent to perform services.
   - 16-Claim/service lacks information which is needed for adjudication.

Background

Is date of service January 27, 2020 eligible for Medical Fee Dispute Resolution (MFDR) in accordance with 28 TAC §133.307?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $1,949.74 psychological exam and services rendered on January 27, 2020.
2. 28 TAC §133.307(c)(1) states: "Timeliness. A requestor shall timely file the request with the DWC's MFDR Section or waive the right to MFDR. The DWC shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute."
3. The DWC reviewed the submitted documentation and finds:
   - The request for medical dispute resolution was received in MFDR on March 11, 2021.
   - The disputed date of service is January 27, 2020.
   - The disputed services do not involve issues identified in §133.307(c)(1)(B).
   - One year from January 27, 2020 is January 27, 2021.
   - The requestor did not file this dispute with the DWC's MFDR Section within the one-year deadline set out in 28 TAC §133.307.

Conclusion

The DWC finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute, as addressed in 28 TAC §133.307(c)(1) and (c)(1)(A). For that reason, the merits of the issues raised by the parties to this dispute for those dates have not been addressed.

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 services in dispute.

Authorized Signature

		3/31/2021
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.