



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

David Lerner PHD, PLLC

Respondent Name

Service Lloyds Insurance Co

MFDR Tracking Number

M4-24-2434-01

Carrier's Austin Representative

Box Number 60

DWC Date Received

June 28, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 3, 2023	90791	\$0.00	\$0.00
October 9, 2023	96138	\$0.00	\$0.00
October 9, 2023	96139	\$767.28	\$0.00
October 27, 2023	96132	\$243.56	\$0.00
October 27, 2023	96133	\$1,857.10	\$0.00
Total		\$2,867.94	\$0.00

Requestor's Position

"David Lerner PhD obtained the appropriate authorizations as required for a non-network provider as supported in the enclosed documents including the physician referral, medical records, preauthorization requests and time documentation relevant information to support the units billed for the neuropsychological panel are attached for review."

Supplemental response received October 9, 2024

"My provider stated he believes he received pmt but was unable to provide the EOB. In calling Mitchell for the EOB the representative was unable to find an additional payment."

Amount in Dispute: \$2,867.94

Respondent's Position

"We have reprocessed previously unauthorized services CPT Code 096132[sic], CPT Code 96139 and CPT Code 96133 for an additional amount to be paid of \$2867.94 along with interest due of \$104.37 for a Total additional payment of \$2,972.31. Please see the attached reconsideration EOR and DWC-60."

Response Submitted by: Mitchell

Findings and Decision

Authority

This medical fee dispute is decided according to [Texas Labor Code \(TLC\) §413.031](#) and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.
2. [28 TAC §134.203](#) sets out the reimbursement guidelines for professional medical services.

Denial Reasons

The insurance carrier adjudicated the payment for the disputed services with the following claim adjustment codes:

- 188 – Payment of interest/penalty to provider
- 225 – Penalty or interest payment by payer.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- U03 – This billed service was reviewed by UR and authorized.
- U05 – This billed service exceeds the UR amount authorized.
- 95 – Plan procedures not followed.

Issues

1. What services are in dispute?
2. What rule is applicable disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor submitted a DWC60 for professional medical services rendered in October of 2023. The date of service October 3, 2023, for code 90791 shows "0" amount in dispute and will not be considered in this review. Additionally, date of service October 9, 2023, for code 96138 indicates "0" amount in dispute. These two codes will not be considered in this review.

The carrier's denial for lack of prior authorization was not maintained. Documentation submitted by the insurance carrier in response to the MFDR request indicates a payment in the amount of \$2,972.31 via check no 302461 dated July 12, 2024, made payable to the requestor at the address shown on the DWC60. The requestor chose to continue with MFDR.

2. DWC Rule 28 TAC §134.203(c)(1) states, "...To determine to MAR for professional services, system participants shall apply the Medicare payment policies with minimal modification...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 \$53.68..."

The following formula represents the calculation of the DWC MAR at §134.203 (c)(1) & (2).

$(\text{DWC Conversion Factor} \div \text{Medicare Conversion Factor}) \times \text{Medicare Payment} = \text{MAR}$

- Code 96132 - CMS Medicare payment for locality (Plano) is $\$127.31 \times 64.83/33.8872 = \243.56 . Submitted evidence indicates the insurance carrier paid \$243.56.
 - Code 96133 - CMS Medicare payment for locality (Plano) is $\$97.07 \times 64.83/33.8872 = \$185.71 \times 10 \text{ units} = \$1,857.06$. Submitted evidence indicates the insurance carrier paid \$1,857.10.
 - Code 96139 - CMS Medicare payment for locality (Plano) is $\$33.42 \times 64.83/33.8872 = \$63.94 \times 12 \text{ units} = \767.23 . Submitted evidence indicates the insurance carrier paid \$767.28.
3. As shown above, the greater weight of evidence indicates the disputed services were paid at or above fee guideline. No additional payment is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requestor has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

October 22, 2024

Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option three or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in [28 TAC §141.1 \(d\)](#).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción tres o correo electrónico CompConnection@tdi.texas.gov.