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
ALLISON WALLS, PHD

Respondent Name
ASCENSION HEALTH ALLIANCE

MFDR Tracking Number
M4-20-2229-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
MAY 4, 2020

REQUESTOR'S POSITION SUMMARY

"The carrier has reduced this claim inappropriately and not in accordance and compliance with TDI-DWC Rule 133 and 134."

July 22, 2020 email regarding CPT code 90785: "Yes that payment was received."

Amount in Dispute: $640.90 - $25.92 (additional payment made) = $614.98

RESPONDENT'S POSITION SUMMARY

"96116 denied because it bundled and covered by billed code 90838 so separate reimbursement not owed. 90838 denied because this code must be billed with one of these based codes in order to pay (99201-99255, 99304-99337, 99341-99350) and it was not. 90839 is also bundled and covered by billed code 90838 and covered by that code so separate reimbursement not owed. 90785 should be paid @ $25.92 and is being paid by Self-Insured."

Response Submitted by: Downs Stanford, PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 7, 2020	CPT Code 96116 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	$166.37	$0.00
	CPT Code 96132 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	$0.00	$0.00

	decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour		
January 7, 2020	CPT Code 96133 (X14) 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)	$0.00	$0.00
	CPT Code 96136 Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes	$0.00	$0.00
	CPT Code 96137 (X7) 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)	$0.00	$0.00
	CPT Code 90838 Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	$202.42	$0.00
	CPT Code 90839 Psychotherapy for crisis; first 60 minutes	$246.19	$0.00
	CPT Code 90785 Interactive complexity (List separately in addition to the code for primary procedure)	$0.00	$0.00
TOTAL		$614.98	$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 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.
3. The services in dispute were reduced / denied by the respondent with the following claim adjustment reason codes:
    - 97-Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
    - 906-In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code Editor), component code of comprehensive medicine, evaluation and management services procedure (90000-99999) has been disallowed.
    - 107-Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim.
    - 292-This procedure code is only reimbursed when billed with the appropriate initial base code.
    - 193-Original payment decision is being maintained. This claim was processed properly.
    - W3-Additional payment made on appeal/reconsideration.

Issues

Is the requestor entitled to additional reimbursement for psychological services rendered on January 7, 2020?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $614.98 for CPT codes 96116, 90838 and 90839 rendered on January 7, 2020.
2. To determine if the respondent's reduction of payment is supported, the DWC refers to the following statute:
   - 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."
3. CPT code 96116:

   The respondent denied payment for code 96116 based upon "97" (code description listed above).

   On the disputed date of service, the requestor billed CPT codes CPT codes 96116, 96132, 96133, 96136, 96137, 90838, 90839, and 90785.

   Per CCI edits, code 96116 is a component of code 90838; however, a modifier is allowed to differentiate the service. A review of the requestor's billing finds the requestor did not append a modifier to code 96116; therefore, the respondent's denial of payment is supported.
4. CPT code 90838:

   The respondent denied payment for code 90838 based upon "107" and "292" (codes description listed above).

   NCCI Policy Manual, Chapter 11, (C), effective January 1, 2020 states in part, "CPT codes 90832-90838 include all psychotherapy provided to a patient with family members as informants, if present, for a single date of service. Family psychotherapy (e.g., CPT codes 90846, 90847) focused on the patient addressing interactions between the patient and family members may be reported separately with psychotherapy CPT codes 90832-90838 on the same date of service if performed as a separate and distinct service during a separate time interval."

   NCCI Policy Manual, Chapter 1, (R), effective January 1, 2020 states in part,

   > Some codes in the "CPT Manual" are identified as "add-on" codes (AOCs), which describe a service that can only be reported in addition to a primary procedure. "CPT Manual" instructions specify the primary procedure code(s) for most AOCs. For other AOCs, the primary procedure code(s) is (are) not specified**.** When the "CPT Manual" identifies specific primary codes, the AOCs shall not be reported as a supplemental service for other HCPCS/CPT codes not listed as a primary code.

   Per Medicare's website regarding *Add-On Codes* referencing *Medicare Claims Processing, Transmittal 2636, Change Request 7501*:

   > An AOC is a HCPCS/CPT code that describes a service that, with rare exception, is performed in conjunction with another primary service by the same practitioner. An AOC is rarely eligible for payment if it is the only procedure reported by a practitioner.
   >
   > Add-on codes may be identified in three ways:
   >
   > 1. The code is listed in this CR or subsequent ones as a Type I, Type II, or Type III add-on code.

2. On the Medicare Physician Fee Schedule Database an add-on code generally has a global surgery period of "ZZZ".
3. In the *CPT Manual* an add-on code is designated by the symbol "**+**". The code descriptor of an add-on code generally includes phrases such as "each additional" or "(List separately in addition to primary procedure)."

CMS has divided the add-on codes into three groups to distinguish the payment policy for each group.

1. Type I - A Type I add-on code has a limited number of identifiable primary procedure codes. The CR lists the Type I add-on codes with their acceptable primary procedure codes. A Type I add-on code***, with one exception,*** is eligible for payment if one of the listed primary procedure codes is also eligible for payment to the same practitioner for the same patient on the same date of service. Claims processing contractors must adopt edits to assure that Type I add-on codes are never paid unless a listed primary procedure code is also paid.

CPT code 90838 is classified as a Type I code. Therefore, the above referenced guidelines apply. Based upon this guideline, CPT code 90838 may not be reimbursed unless the primary code (99201-99255, 99304-99337, 99341-99350) is reimbursed. The requestor did not bill the primary code. As a result, reimbursement is not recommended.

5. CPT code 90839:

The respondent denied payment for code 90839 based upon “97” and “906”. (codes description listed above).

Per CCI edits, code 90839 is a component of code 90838 and a modifier is not allowed to differentiate the service; therefore, the respondent’s denial of payment is supported.

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

		7/29/2020
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 Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division 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 Division. **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.