Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Respondent Name
TEXAS MUNICIPAL LEAGUE INTERGO

MFDR Tracking Number
M4-21-2290-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
August 12, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 02, 2020	Code 96116	$0.00	$0.00
December 02, 2020	Code 96132	$0.00	$0.00
December 02, 2020	Code 96133 x 14	$1,198.58	$0.00
December 02, 2020	Code 96136	$0.00	$0.00
December 02, 2020	Code 96137 x 9	$0.00	$0.00
	Total	$1,198.58	$0.00

Requestor's Position

The Carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134 ... We are providing supporting documentation specifically explaining and outlining our position in accordance with Rule 127.10, 133 and 134 of the TDI-DWC Rules and Regulations governing bills/claims submitted in reference to DESIGNATED DOCTOR REFERRED TESTING

Amount in Dispute: $1,198.58

Respondent's Position

No additional reimbursement is owed to the provider as the documentation does not support the number of hours billed. The procedures described by the CPT codes (96132, 96133, 96136)

are time procedures based on NCCI Policy Manual Chapter 11 (M)(2), "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 provider failed to submit the starting and ending time for procedure codes 96132, 96133, 96136 and 96137."

Response Submitted by: Flahive, Ogden & Latson

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §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 fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system.

3. 28 TAC §127.10, effective November 4, 2018, sets out the Designated Doctor procedures and requirements.

Denial Reasons

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

- 97 – The benefit for this service is
- 641 – The medically unlikely edits (MUE) from CMS has been applied to this procedure code
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- 350 – Bill has been identified as a request for reconsideration or appeal
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal

Issues

1. Is Requestor entitled to additional reimbursement?

Findings

1. The requestor in dispute is seeking medical fee dispute resolution in the amount of $1,198.08 for CPT codes 96133 date of service December 02, 2020.

The respondent reduced payment code 96133 based on "641 – The medically unlikely edits (MUE) from CMS has been applied to this procedure code."

To determine if the respondent's denial is supported, the DWC refers to the following:

- The fee guideline for the disputed service can be 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, "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."
- 28 TAC §134.203(a)(7) states, "Specific provisions contained in the Texas Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by CMS in administering the Medicare program. Independent Review Organization (IRO) decisions regarding medical necessity made in accordance with Labor Code §413.031 and §133.308 of this title (relating to MDR by Independent Review Organizations), which are made on a case-by-case basis, take precedence in that case only, over any Division rules and Medicare payment policies."
- 28 TAC §127.10(c) states, "The designated doctor shall perform additional testing when necessary to resolve the issue in question. The designated doctor shall also refer an injured employee to other health care providers when the referral is necessary to resolve the issue in question and the designated doctor is not qualified to fully resolve the issue in question. Any additional testing or referral required for the evaluation is not subject to preauthorization requirements nor shall those services be denied retrospectively based on medical necessity, extent of injury, or compensability in accordance with the Labor Code §408.027 and §413.014, Insurance Code Chapter 1305, or Chapters 10, 19, 133, or 134 of this title (relating to Workers' Compensation Health Care Networks, Agents' Licensing, General Medical Provisions, and Benefits--Guidelines for Medical Services, Charges, and Payments, respectively) but is subject to the requirements of §180.24 of this title (relating to Financial Disclosure)."

Medicare developed MUE's to detect potentially medically unnecessary services. These MUEs set a maximum number of units allowed for a specific service on a single date of service. The DWC finds Medicare's MUE payment policy is in direct conflict with 28 TAC §127.10(c) which sets out the designated doctor procedures. The DWC concludes that Rule §127.10 take precedence over Medicare MUEs.

The respondent also denied payment for code 96133 based upon "The benefit for this service is included in the payment/allowance for another service/procedure that has already been

adjudicated."

The requestor billed CPT codes 96116, 96132, 96133, 96136 and 916137. These codes are described as:

- 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."

- 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 decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour."

- 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)."

- 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."

- 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)."

As noted from the code descriptors, code 96133 and 96137 are timed procedures. They are also billed as secondary codes to 96132 and 96136 for additional time.

NCCI Policy Manual, Chapter 11, (M)(2), effective January 1, 2021 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 documentation provided by the requestor notes on the Neuropsychological Evaluation report that the claimant underwent 15 hours of Neuropsychological testing; 1 hour of

Examinee Interview & Neurobehavioral/Mental Status exam and 5 hours of Neuropsychological Testing & Scoring exam for a total test time of 21 hours.

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 96116, 96132, 96133, 96136 and 96137 to support the number of hours billed. The requestor has not supported request for additional reimbursement of code 96133.

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 requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature

[redacted] [redacted] September 15, 2021

g 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 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 3 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 3 o correo electronico CompConnection@tdi.texas.gov.