



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Gabriel Jasso PHD

Respondent Name

Acuity A Mutual Insurance Co

MFDR Tracking Number

M4-21-2322-01

Carrier's Austin Representative

Box Number 17

DWC Date Received

August 17, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 1, 2021	96133	\$353.43	\$0.00
June 1, 2021	96137	\$565.00	\$0.00
Total		\$918.43	\$0.00

Requestor's Position

The Doctor would be going above and beyond to include an itemized breakdown as the time is not for just one day.

Amount in Dispute: \$918.43

Respondent's Position

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.

Response Submitted by: Corvel

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 Texas Administrative Code (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. Texas Labor Code 413.014 provides the preauthorization requirements, concurrent review and certification of health care.
4. 28 TAC §134.600 sets out the procedure for obtaining preauthorization.

Denial Reasons

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

- RA1 – Medical Unlikely Edit; DOS exceeds MUE value
- P13 – Payment reduced/denied based on state WC regs/polices

Issues

1. Is the insurance carrier's denial based on Medical Unlikely Edits supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of \$918.43 for CPT codes 96133 and 96137 rendered on June 1, 2021.

The respondent reduced payment for codes 96133 and 96137 based upon "RAI-The Medically Unlikely Edits(MUE) from CMS has been applied to this procedure code."

Although the DWC adopts Medicare payment policies by reference in applicable Rule §134.203, paragraph (a)(7) of that rule states that specific provisions contained in the Division of Workers' Compensation rules shall take precedence over any conflicting provision adopted the Medicare program.

The Medicare MUE payment policy is in direct conflict with Texas Labor Code §413.014 which requires that all determinations of medical necessity shall be made prospectively or retrospective through utilization review; and with Rule §134.600 which sets out the procedures

for preauthorization and retrospective review of professional services such as those in dispute here. The DWC concludes that Labor Code §413.014 and 28 TAC §134.600 take precedence over Medicare MUE's; therefore, the respondent's denial reasons are not supported.

2. The insurance carrier referenced Division Workers Comp regulations to deny the disputed charges. As stated above DWC requires system participants to apply Medicare billing and coding policies which requires for timed codes the total time (including start and stop time) must be supported.

The requestor noted on the Neuropsychological Examination 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 10 hours of Neuropsychological testing evaluation; 4 hours of Examinee Interview & Neurobehavioral/Mental Status exam; and 10 hours of Neuropsychological Testing & Scoring.

The report does not list the start and end time of time procedure codes to support the number of hours billed. The requestor has not supported request for reimbursement of codes 96133 and 96137.

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 [not] entitled to additional reimbursement for the disputed services.

_____	_____	October 5, 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 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 electrónico CompConnection@tdi.texas.gov.