TDI 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
Gabriel Jasso PhD

Respondent Name
Standard Fire Insurance Co

MFDR Tracking Number
M4-23-1342-01

Carrier's Austin Representative
Box Number 5

DWC Date Received
February 8, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 29, 2022	96133	$376.54	$0.00
March 29, 2022	96137	$596.97	$0.00
March 29, 2022	96116	$0.00	$0.00
March 29, 2022	96121	$0.00	$0.00
March 29, 2022	96132	$0.00	$0.00
March 29, 2022	96136	$0.00	$0.00
	Total	$973.51	$0.00

Requestor's Position

"The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134. The carrier has not responded or has denied this claim in its entirety following our filing of Request for Reconsideration. ...Please note from the attached testing results & supporting documentation, that all components for this claim were performed and billed appropriately using the TDI-DWC Fee Guidelines and should not be reduced. This claim was billed per Medical Fee Guideline conversion factors as established in 28 Texas Administrative Code 134.203."

Amount in Dispute: $973.51

Respondent's Position

"The Provider contends they are entitled to reimbursement or additional reimbursement for CPT codes 96133 and 96137 re3lated to the testing and evaluation. As to CPT code 96133 (additional neuropsychological testing, per hour), the Provider contends they are entitled to addition reimbursement. The Provider billed 9 units for this CPT code on the single date of service, corresponding to 9 hours of additional testing that day above the original hour reflected in CPT code 96132, for a total of 10 hours of testing. The Medicare edits limit reimbursement for this code to 7 unit per day under the Medicare Unlikely Edits. On page 2 of his report, the Provider notes that he conducted 24 ours of testing, evaluation, and examination on this single date of service. Given that the CPT code also includes reviewing the results and drafting the report, the Carrier reimbursed the Provider at the full Medicare edit allowed of 7 units. The Provider has not submitted documentation to substantiate additional time on separate dates of service. As the Medicare edits allow only 7 units of this CPT code per day, which the Carrier has reimbursed, the Provider is not entitled to additional reimbursement."

Response submitted by: Travelers

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 Texas workers' compensation system.
3. 28 TAC §127.10 sets out the Designated Doctor procedures and requirements.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- W3 – Bill is reconsideration or appeal
- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

- 947 – Upheld no additional allowance has been recommended
- 2005 – N o additional reimbursement allowed after review of appeal/reconsideration
- 3244 – The billing of the procedure code has exceeded the National Correct Coding Initiative Medically Unlikely edits amount for the number of times this procedure can be billed on date of service. An allowance has not been paid

Issues

1. Is the Requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for professional medical services rendered in March of 2022. The codes in dispute are,

    - 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), 9 units.
    - 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), 19 units.

    The insurance reduced the payment for these two codes as,

    - 97 – Payment adjusted because the benefit for this service is include in the payment/allowance for another service/procedure that has already been adjudicated.
    - 3244 – The billing of the procedure code has exceeded the National Correct Coding Initiative Medically Unlike edits amount for the number of times this procedure can be billed on a date of service.

    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(a)(5) which 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."

DWC Rule 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."

DWC Rule 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."

DWC Rule 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 the codes in dispute as "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated."

Review of the submitted medical bill contained CPT codes 96133, 96137, 96116, 96121, 96132, and 96136.

These codes are described as:

- 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 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)."
- 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 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)
- 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 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."

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), 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.

The requestor noted on the Neuropsychological Examination report that the claimant underwent 10 hours of Neuropsychological testing evaluation services; 4 hours of Examinee Interview & Neurobehavioral/Mental Status Exam services; and 10 hours of Neuropsychological Testing and Scoring, for a total of 24 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, 96121, 96132, 96133, 96136, and 96137 to support the number of hours billed.

The requestor has not supported the request for additional 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 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

Signature	Medical Fee Dispute Resolution Officer	March 30,2023 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.