Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
GABRIEL JASSO, PHD

Respondent Name
TRAVELERS INDEMNITY COMPANY

MFDR Tracking Number
M4-23-1589-01

Carrier's Austin Representative
Box Number 05

DWC Date Received
March 8, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 5, 2022	96133 and 96137	$918.56	$0.00
	Total	$918.56	$0.00

Requestor's Position

"DESIGNATED DOCTOR REFERRED TESTING INCORRECT REDUCTION."

Amount in Dispute: $918.56

Respondent's Position

"As to CPT code 96133 (neuropsychological testing, per hour), the Provider contends they are entitled to additional reimbursement. The Provider billed 9 units for this CPT code on the single date of service, corresponding to 9 hours of testing that day. The Medicare edits limit reimbursement for this code to 7 units per day under the Medicare Unlikely Edits.... As to CPT code 96137 (psychologist administered psychological testing, additional 30 minutes), the Provider contends they are entitled to additional reimbursement... The Medicare edits again limit reimbursement for this code to 11 units per day under the Medicare Unlikely Edits. Again, there is no documentation in the Provider's report reflecting the duration of this testing. 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 11 units. The Provider has not submitted documentation to substantiate additional time. As the Medicare edits allow only 11 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 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203 sets out the fee guideline for professional medical services.

Denial Reasons

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment 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.
- 3244 – The bill 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 a date of service. An allowance has not been paid.
- W3 – Bill is a reconsideration or appeal.
- 947 – Upheld, no additional allowance has been recommended.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. What are the services in dispute?
2. Is the Insurance Carrier's denial reason(s) supported?
3. Is the Requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for psychological services rendered on April 5, 2022. The insurance carrier issued a total reimbursement of $2,941.91 and the requestor seeks an additional payment in the amount of $918.56. The table below outlines the disputed amounts:

CPT Code	Disputed Amount	Insurance Carrier Paid	Amount in dispute
96116	$167.92	$167.92	$0.00
96121	$421.08	$421.08	$0.00
96132	$232.47	$232.47	$0.00
96133	$1,622.88	$357.21	$357.21
96136	$77.95	$77.95	$0.00
96137	$1,338.17	$563.35	$561.35
	$3,860.47	$2,941.91	$918.26

The requestor seeks additional reimbursement for CPT codes 96133 and 96137.

2. To determine if the respondent’s denial 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.”
   - 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.”

   On the disputed date of service, the requestor billed CPT codes 96116, 96121, 96132, 96133, 96136, and 96137. These codes are described as:

   - CPT code 96116 – “Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [e.g., 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, [e.g., 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 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, codes 96116, 96121, 96132, 96133, 96136, and 96137 are timed procedures. CPT codes 96121, 96133 and 96137 are billed as ad-on/secondary codes to 96116, 96132, and 96136.

Per Medicare's payment policies:

CPT 96133 - " Per Medicare's Medically Unlikely Edits, the units of service billed for procedure code 96133 exceed the allowed number of units of 7 in 1 Day for date of service edit."

CPT 96137, "Per Medicare's Medically Unlikely Edits, the units of service billed for procedure code 96137 exceed the allowed number of units of 11 in 1 Day for date of service edit."

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.)

Review of the NCCI Policy Manual, Chapter 11, (M)(2), states in relevant part, "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."

Per the reasons indicated above, the requestor is not entitled to additional reimbursement for the disputed CPT codes 96133 and 96137. As a result, $0.00 is recommended.

3. The DWC finds that the requestor has not supported the additional reimbursement for CPT codes 96133 and 96137 is due.

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.

The DWC finds the requester has established that reimbursement of $0.00 is due.

Order

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

Authorized Signature

______________________	______________________	June 5, 2023
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 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 3 o correo electronico CompConnection@tdi.texas.gov.