



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Walls Allison PhD

**Respondent Name**

Sirius America Insurance Co

**MFDR Tracking Number**

M4-23-1706-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

March 16, 2023

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 20, 2022	96116	\$0.00	\$0.00
June 20, 2022	96132	\$0.00	\$0.00
June 20, 2022	96133	\$1299.34	\$0.00
June 20, 2022	96136	\$0.00	\$0.00
June 20, 2022	96137	\$0.00	\$0.00
<b>Total</b>		<b>\$1299.34</b>	<b>\$0.00</b>

### Requestor's Position

"Please note that the CPT codes and MAR are not bundled nor compounded and are to be billed and reimbursed separately and independently from one another. All components were performed and billed accordingly based on the TDI-DWC Fee Guidelines and per Rule 133 and Rule134 respectively."

**Amount in Dispute:** \$1299.34

### Respondent's Position

"Given no violation of the Workers' Compensation Act or division rules, CorVel respectfully

requests the division issue a decision indicating the requestor, Alison Walls, PhD is entitled to \$0.00 reimbursement for date of service 06/20/2022 based on Rule 134.203 Medica Fee Guideline for Professional Services, (a)(5) "Medicare payment policies."

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 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203 sets out the billing requirements for professional services.

### Denial Reasons

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

- P13 – Payment reduced/denied based on state WC regs/policies
- R&I – Medical Unlikely Edit: DOS exceeds MUE value

### Issues

1. Is the insurance carrier's denial supported?
2. Is the number of units of disputed service supported?

### Findings

1. The requestor is seeking additional reimbursement for 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).

The insurance carrier denied the claim based on Medicare's Medically Unlikely Edits. DWC Rule 28 TAC 134.203 (b) states in pertinent part, for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits.

MUE's set a maximum number of units for a specific service that a provider would report under most circumstances for a single patient on a single date of service. Medicare developed MUE edits to detect potentially medically unnecessary services.

Although the DWC adopts Medicare payment policies by reference in applicable DWC Rule 28 TAC §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 DWC Rule 28 TAC §134.600 take precedence over Medicare MUE's; therefore, the respondent's denial reasons are not supported.

2. The requestor submitted a medical bill for fourteen units of 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.

Review of the submitted documentation does not show the start and end time of the submitted code.

Insufficient evidence was found to support the total time and/or number of units submitted for code 96133. No payment recommended.

### 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**

April 13, 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](http://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](mailto: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](mailto:CompConnection@tdi.texas.gov).