TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Jasso, Gabriel PhD

Respondent Name
Standard Fire Insurance Co

MFDR Tracking Number
M4-23-1919-01

Carrier's Austin Representative
Box Number 5

DWC Date Received
April 5, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 6, 2023	96116	$0.00	$0.00
January 6, 2023	96121	$0.00	$0.00
January 6, 2023	96132	$0.00	$0.00
January 6, 2023	96133	$380.67	$0.00
January 6, 2023	96136	$0.00	$0.00
January 6, 2023	96137	$607.77	$0.00
	Total	$988.44	$0.00

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 Rule 134 respectively."

Amount in Dispute: $988.44

Respondent's Position

"… CPT code 96133 (neuropsychological testing, per hour)… …The Provider billed 9 units for this CPT code on the single date of service, corresponding to 4.5 hours of testing that day. The

Medicare edits limit reimbursement for this code to 7 unit per day under the Medicare Unlikely Edits. 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 units. …As to CPT code 96137 (psychologist administer psychological testing, additional 30 minutes), the Provider contends they are entitled to additional reimbursement. The Provider billed 19 units for the CPt code on the single date of service, corresponding to 9.5 hours of additional testing that day… Given that the CPT code also includes reviewing the results and drafting the report, the Carrier reimbursed the Provider for the maximum 11 units. As the Carrier has reimbursed for the documented testing under the edits, 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 §133.307 sets out the requirements of medical fee dispute resolution.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.

Denial Reasons

The insurance carrier 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.
- 947 – Upheld. No additional allowance has been recommended.
- 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 a date of service. An allowance has not been paid.

Issues

1. Is the insurance carrier's denial supported?
2. Did the requestor support the total number of units billed?
3. What rule is applicable to disputed services?

Findings

1. The requestor is seeking reimbursement of $988.44 for codes,
    - 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) and
    - 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).

    The insurance carrier reduced the allowed number of units based on the Medicare Unlikely Edits.

    DWC Rule 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."

    DWC Rule 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."

    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."

    Medicare developed MUEs 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) designated doctor procedures. The DWC finds that Rule §127.10 take precedence over Medicare MUEs.

2. As shown above DWC Rule 28 TAC §134.203(b)(1) states in pertinent part, "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

    Review of the "Neuropsychological Examination" indicates,

    - Neuropsychological testing evaluation services 10hr(s)
    - Examinee Interview & Neurobehavioral/Mental Status Exam 4hr(s)

- Neuropsychological Testing & Scoring 10hr(s)

Review of the medical documentation found insufficient evidence to support the number of units reported either on the medical bill or the neuropsychological examination.

3. The CMS NCCI Manual CHAPTER XI, Medicine, Evaluation and Management Services Cpt Codes 90000 – 99999, for, Medicare National Correct Coding Initiative Policy Manual M. Central Nervous System Assessments/Tests, Section 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, providers/suppliers ***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***.

   Based on the above, DWC finds the applicable NCCI edit does not allow reporting of 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 with Code 96133.

   No additional payment is recommended.

Authorized Signature

		May 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 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.