



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Jasso Gabriel PhD

Respondent Name

Comal ISD

MFDR Tracking Number

M4-23-3030-01

Carrier's Austin Representative

Box Number 29

DWC Date Received

August 2, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 5, 2023	96116	\$5.03	\$0.00
January 5, 2023	96121	\$10.32	\$0.00
January 5, 2023	96132	\$7.22	\$0.00
January 5, 2023	96133	\$68.52	\$0.00
January 5, 2023	96136	\$3.40	\$0.00
January 5, 2023	96137	\$17.13	\$0.00
Total		\$137.91	\$0.00

Requestor's Position

"The carrier has reduced this claim inappropriately and not in accordance and compliance with TDI-DWC Rule 133 and 134. The carrier has not responded or denied this claim in its entirety following our filing of Request for Reconsideration. We are providing supporting documentation specifically explaining and outlining our position in accordance with Rule 133 and 134 governing bills/claims submitted in reference to workers compensation treatment and services."

Amount in Dispute: \$137.91

Respondent's Position

“ It appears the provider is requesting 100% payment for the services rendered. The provider is located in Houston, TX, which if services were rendered there, would pay 100% per fee schedule. Based on the medical bill filed, however, services were incurred in San Antonio, TX, which has a different fee schedule. Attached are copies of bills and EOB’s documenting payments issued. It is our position that payment issued were correct based on service location and no additional reimbursement is due.”

Response submitted by: Claims Administrative Services, Inc.

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.

- 641 – The medical unlikely edits (MUE) from CMS has been applied to this procedure code.
- 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
- 198 – Precertification/notification/authorization/pre-treatment exceeded.
- P12 – Workers’ compensation jurisdictional fee schedule adjustment.
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 720 – Preauthorization was approved for a maximum of 4 units per session. Units billed exceed preauthorization amount for date of service.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. Is the insurance carrier's denial supported?
2. Are the number of units of disputed service supported?
3. What rule is applicable to reimbursement?

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) and 96137 – the provider, a physician or other qualified healthcare professional, administers two or more psychological or neuropsychological tests and scores them requiring an additional 30 minutes beyond the initial 30 minutes.

The insurance carrier reduced the number of allowed units as the Medically Unlikely Edits (MUE) from CMS has been applied to this procedure code.

MUE's were implemented by Medicare in 2007. 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 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.

Additionally, the insurance carrier denied code 96133 stating precertification/notification/authorization/pre-treatment exceeded. Review of the submitted documentation found insufficient evidence to support the insurance carrier did not prior authorize the total number of units. This denial is also not supported.

2. DWC 28 134.203 (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.

The Medicare National Correct Coding Initiative Policy Manual (NCCI) manual found at www.cms.gov, Chapter XI, Evaluation and Management Services, CPT Codes 90000 – 99999, Section M, 2, states, *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.*

Insufficient evidence was found to support the total submitted time of twenty-four hours for testing, evaluation and scoring. No payment recommended.

3. DWC Rule 28 TAC §134.203 states in pertinent part, "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
 - (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83...
 - (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year..."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = Maximum Allowable Reimbursement (MAR).

- The 2023 DWC Conversion Factor is 64.83
- The 2023 Medicare Conversion Factor is 33.8872
- The CMS 1500 indicates the services were rendered in zip code 78228; the Medicare locality is "Rest of Texas."

Submitted Code	CMS Physician Fee Schedule Allowable	64.83/33.8872 x CMS allowable = MAR	Carrier paid	Difference between MAR and paid amount
96116	\$91.16	\$174.40	\$174.40	\$0.00
96121	\$74.75	\$429.02	\$429.03	\$0.00
96132	\$127.31	\$243.56	\$243.58	\$0.00
96136	\$41.37	\$79.15	\$79.15	\$0.00

The DWC finds no additional payment 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.

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 entitled to \$0.00 additional reimbursement for the disputed services.

Authorized Signature

		August 31, 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 electrónico CompConnection@tdi.texas.gov.