



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Jasso Gabriel PhD

**Respondent Name**

Texas Association of Counties Risk Mgmt

**MFDR Tracking Number**

M4-24-1318-01

**Carrier's Austin Representative**

Box Number 47

**DWC Date Received**

February 15, 2024

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 20, 2023	96121	\$142.77	\$0.00
June 20, 2023	96121	\$0.00	\$0.00
June 20, 2023	96131	\$0.00	\$0.00
June 20, 2023	96136	\$0.00	\$0.00
June 20, 2023	96137	\$0.00	\$0.00
<b>Total</b>		<b>\$0.00</b>	<b>\$0.00</b>

### 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."

**Amount in Dispute:** \$142.77

### Respondent's Position

"Respondent reimbursed Dr. Jasso \$2374.33, reducing the bill by \$142.77 for CPT code 96121. Respondent contends that no reimbursement is owed for CPT 96121 as this CPT code should only

be billed as an add-on/secondary code to CPT 96116.”

**Response submitted by:** Burns Anderson Jury & Brenner, LLP

## **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.

- 292 – This procedure code is only reimbursed when billed with the appropriate initial base code.
- 107 – Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim.

### Issues

1. Is the insurance carrier’s denial supported?

### Findings

1. The requestor is seeking reimbursement for CPT code 96121 for date of service June 20, 2023. The submitted DWC lists.
  - 96121 – Disputed amount \$142.77
  - 96121 – Disputed amount \$0.00
  - 96131 - Disputed amount \$0.00
  - 96136 - Disputed amount \$0.00
  - 96137 - Disputed amount \$0.00

Review of Code 96121 will be the only code considered in this review.

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 Chapter I, Section "R" at [www.cms.gov](http://www.cms.gov) states, "Some codes in the "CPT Manual" are identified as "Add-on" Codes (AOCs), which describe a service that **can only be reported in addition to a primary procedure.**"

Review of the code description for code 96121 – *Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgement, [eg, acquire 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*, is listed as an add-on code and should have been reported in addition to primary procedure. The insurance carrier's denial is supported. No payment is 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 entitled to \$0.00 additional reimbursement for the disputed services.

### **Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
Date

March 15, 2024

### **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).