



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requester Name**

Gabriel Jasso, PSYD

**Respondent Name**

Praetorian Insurance Co.

**MFDR Tracking Number**

M4-25-2589-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

June 19, 2025

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 13, 2024	96116-59	\$184.01	\$0.00
	96121-59	\$452.22	\$0.00
	96132-59	\$256.55	\$0.00
	96133-59	\$2,335.92	\$0.00
	96136-59	\$82.26	\$0.00
	96137-59	\$965.12	\$0.00
<b>Total</b>		<b>\$4,276.08</b>	<b>\$0.00</b>

### Requester's Position

"The carrier has incorrectly denied this claim in its entirety... Carrier denied the bill for payment after no payment RFR was filed."

**Amount in Dispute: \$4,276.08**

### Respondent's Position dated July 7, 2025

"The provider claims the carrier has not paid the provider any monies. The provider is currently seeking payment of \$4,276.08. However, the provider's DWC 60 packet includes an EOR dated October 15, 2024 that recommended payment of \$3,149.51. The provider's position statement

dated June 18, 2025 claims the carrier denied the bill for payment after no payment and a RFR was filed. Documentation below it has some instructions concerning cutting and pasting different documents. The provider's position statement fails to reconcile itself with the carrier's EOR dated October 15, 2024. The provider is not entitled to any additional monies."

**Respondent's Supplemental Position dated July 21, 2025:** "Carrier has previously responded to this dispute on 07/07/2025. As noted in the carrier's initial response, the carrier paid the provider \$3,149.51, on October 28, 2024. The check number is [redacted]."

**Response Submitted by:** Flahive, Ogden & Latson

## Findings and Decision

### Authority

This medical fee dispute is decided according to [Texas Labor Code \(TLC\) §413.031](#) and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

### Statutes and Rules

1. [28 TAC §127.10, effective April 30, 2023, 48 TexReg 2123](#), sets out the procedures for designated doctor examinations.
2. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.
3. [28 TAC §134.203](#) sets out the fee guidelines for professional medical services.

### Adjustment Reasons

The insurance carrier reduced or denied payment for the disputed services with the following claim adjustment codes:

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- N640 – Exceeds number/frequency approved/allowed within the time period.
- P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies.

### Issues

1. Have the services in dispute received reimbursement as of the date of this review?
2. What are the applicable rules for the review of the services in this dispute?
3. What are DWC's findings from the review of disputed procedure codes 96116 and 96121?
4. What are DWC's findings from the review of disputed procedure codes 96132, 96133, 96136 and 96137?
5. Is the requester entitled to additional reimbursement?

## Findings

1. The requester asserts in its position statement that no reimbursements have been allowed for the services in dispute. However, a review of the submitted documentation finds an explanation of benefits (EOB) with a finalized date of October 15, 2024, in which the following reimbursements were allowed for the disputed services:

- 96116-59 reimbursement allowed is \$183.75
- 96121-59 reimbursement allowed is \$451.56
- 96132-59 reimbursement allowed is \$256.19
- 96133-59 reimbursement allowed is \$1,360.69
- 96136-59 reimbursement allowed is \$82.14
- 96137-59 reimbursement allowed is \$815.21

Per the EOB submitted, reimbursements were allowed in the total amount of \$3,149.51 for the services in dispute. The payee information on the EOB matches the name and address of the billing provider in field 33 of the CMS 1500 medical bill form submitted. According to the EOB, a payment was made via payment ID number [redacted] on October 28, 2024. The payment information on the submitted EOB supports the carrier response assertion that payment has been made in the total amount of \$3,149.51 for the services in dispute.

2. The procedure codes in question are considered professional medical services. DWC will review these services for reimbursement in accordance with relevant rules.

Reimbursement policies for professional services are found in 28 TAC §134.203, which states, in relevant part: "(b) 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."

Reimbursement fee guidelines for professional services are addressed in 28 TAC §134.203(c), which states in relevant part: "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 ..."

3. The requester is seeking reimbursement for procedure code 96116 which is defined as “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. Behavioral exam with interpretation and report. Usually involves clinical assessment of skills in acquired knowledge, attention, memory, visual spatial abilities, language, or planning. The physician or psychologist evaluates aspects of thinking, reasoning, and judgment to evaluate a patient's neurocognitive abilities. These codes apply to each hour of examination time and must include face-to-face time with the patient and time spent interpreting test results and preparing a report. Report 96116 for the initial hour and 96121 for each additional hour.”

On the disputed date of service, the requester billed \$184.01 for one unit of procedure code 96116. They additionally billed \$452.22 for three units of timed add-on code 96121 with modifier 59.

The insurance carrier allowed \$183.75 for one unit of CPT code 96116 and allowed \$451.56 for 3 units of CPT code 96121.

A review of the documentation provided supports that the service described above for procedure code 96116 was performed by the requester for neurobehavioral status examination within the billed dates of service. DWC will review this code for additional reimbursement.

The report does not list the start and end time to support the number of hours billed for add-on timed procedure code 96121; therefore, additional reimbursement is not recommended for this code as defined.

4. The requester is seeking reimbursement for procedure code 96132, which is defined as “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. The physician or other qualified health care professional evaluates and interprets the results of psychological or neuropsychological testing ... Neuropsychological testing consists of a series of tests in thinking, reasoning, judgment, and memory to evaluate the patient's neurocognitive abilities. Report 96132 for the first hour of evaluation/ interpretation and 96133 for each additional hour thereafter. Codes within this range describe the evaluation component, including combining data from different sources, interpreting test results and clinical data, decision-making, and providing a plan of treatment and report, as well as providing interactive feedback with the patient and family members or caregivers. These codes apply to each hour of evaluation and must include face-to-face time with the patient, as well as the time spent integrating and interpreting data; however, the actual test administration and scoring services are not reported by these codes.” Disputed procedure code 96133 is a timed add-on code for procedure code 96132.

On the disputed date of service, the requester billed \$265.55 for one unit of CPT code 96132 and additionally billed \$2,335.92 for 12 units of CPT code 96133.

The insurance carrier allowed \$256.19 for one unit of CPT code 96132 and allowed \$1,360.69 for 7 units of CPT code 96133.

The requester is also seeking reimbursement for procedure code 96136, which is defined as, "Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes. A physician, other qualified health care professional, or technician administers and scores two or more psychological or neuropsychological tests by any method ... neuropsychological testing consists of a series of tests in thinking, reasoning, judgment, and memory to evaluate the patient's neurocognitive abilities. Report 96136 for the initial 30 minutes of time by a physician or other qualified health care professional and 96137 for each additional 30 minutes." Disputed procedure code 96137 is a timed add-on code for procedure code 96136.

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.

The requester charged \$82.26 for one unit of CPT code 96136 and additionally charged \$965.12 for 13 units of CPT code 96137.

The insurance carrier allowed \$82.14 for CPT code 96136 and allowed \$815.21 for 11 units of 96137.

A review of the documentation provided supports that the services described above for procedure codes 96132 and 96136 were performed by the requester for tests administered, scored, evaluated, and interpreted within the billed dates of service. DWC will review these codes for additional reimbursement.

The report does not list the start and end time to support the number of hours billed for add-on timed procedure codes 96133 and 96137; therefore, additional reimbursement is not recommended for these codes as defined.

5. The requester is seeking additional reimbursement in the amount of \$4,276.08 for services rendered on August 13, 2024. As established in previous findings, the procedure codes to be reviewed and adjudicated for additional reimbursement due are CPT codes 96116, 96132, and 96136.

To determine the MAR, the following formula is used:

$(\text{DWC Conversion Factor} / \text{Medicare Conversion Factor}) \times \text{Medicare Participating Amount}$ .

- The rendering date of service is August 13, 2024.
- The DWC conversion factor for 2024 is 67.81.
- The Medicare conversion factor for the disputed date of service is 33.2875.

- Per the submitted medical bills, the service was rendered in zip code 79925 which is in Medicare locality 99, "Rest of Texas."

CPT code 96116

- The Medicare participating amount for CPT code 96116 is \$90.20.
- Using the formula above, the MAR is \$183.75.
- The insurance carrier paid \$183.75.
- Additional reimbursement is not recommended.

CPT code 96132

- The Medicare participating amount for CPT code 96132 is \$125.76.
- Using the formula above, the MAR is \$256.19.
- The insurance carrier paid \$256.19.
- Additional reimbursement is not recommended.

CPT code 96136

- The Medicare participating amount for CPT code 96136 is \$40.32.
- Using the formula above, the MAR is \$82.14.
- The insurance carrier paid \$82.14.
- Additional reimbursement is not recommended.

DWC finds that the requester is not entitled to additional reimbursement for the disputed services rendered on August 13, 2024.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requester 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 requester is entitled to \$0.00 additional reimbursement for the disputed services.

**Authorized Signature**

\_\_\_\_\_  
Signature

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

August 29, 2025  
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 three 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 tres o correo electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).