TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Amended Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name
Gabriel Jasso, PhD

Respondent Name
Federal Insurance Co

MFDR Tracking Number
M4-25-2946-02

Carrier's Austin Representative
Box Number 17

DWC Date Received
July 18, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 8, 2025	96116	$1.85	$0.00
	96121-59	$4.77	$0.00
	96132-59	$2.39	$0.00
	96133-59	$1,035.24	$0.00
	96137-59	$145.26	$0.00
	Total	$1,189.51	$0.00

Requester's Position

"The insurance carrier has not properly paid this claim in accordance with DWC Rules governing the specific services billed."

Amount in Dispute: $1,189.51

Respondent's Position

"The Respondent did not include documentation to support CMS' overriding of MUE for non-WC related billing … Documentation submitted for the HCP's initial billing and request for reconsideration does not support a total of 20 hours of testing and interpretation for the **one** date of service billed."

Response Submitted by: CorVel

Findings and Decision

Authority

By Official Order Number 8468 dated January 12, 2024, the undersigned has been delegated authority by the Commissioner to **amend** fee dispute decisions.

This **amended** findings and decision supersedes all previous decisions rendered in this medical payment dispute involving the above requestor and respondent.

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 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.203 sets out the fee guidelines for professional medical services.

3. 28 TAC §134.600 sets out the procedure for obtaining preauthorization.

4. TLC 413.014 provides the preauthorization requirements, concurrent review and certification of health care.

Denial Reasons

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

- 59 – Distinct Procedural Service
- RAI – Medical Unlikely Edit; DOS exceeds MUE value
- P13 – Payment reduced/denied based on state WC regs/policies
- P12 – Workers' Compensation State Fee Schedule Adj
- 193 – Original payment decision maintained
- 97A – Provider appeal
- B12 – Svcs not documented in patient medical records

Issues

1. Is the insurance carrier's denial based on MUE Edits supported?

2. Is the respondent's position statement supported?

3. Is Gabriel Jasso, PhD entitled to additional reimbursement for the services in question?

Findings

1. The requester is seeking medical fee dispute resolution for professional medical services rendered on April 8, 2025.

   The submitted DWC060 indicates additional payment is requested on the following codes:

   - 96116 – Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, 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;

   - 96121-59 - Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, 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; each additional hour;

   - 96132-59 - Neuropsychological testing evaluation services by physicians or other qualified health care professionals, 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;

   - 96133-59 - 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;

   - 96137-59 - 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.

   To determine if the respondent's denial of payment is supported, the DWC refers to the following rules:

   - 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."

   - 28 TAC §134.203(b) 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."

- 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."

The insurance carrier denied the disputed services based, in part, on the Medically Unlikely Edit (MUE) process. MUEs were implemented by Medicare in 2007. MUEs 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 the MUE process to detect potentially medically unnecessary services.

Although DWC adopts Medicare payment policies by reference in 28 TAC §134.203(a)(7) which provisions contained in DWC rules "shall take precedence over any conflicting provision adopted or utilized by CMS in administering the Medicare program."

The Medicare MUE payment policy is in direct conflict with TLC §413.014, which requires that all determinations of medical necessity shall be made prospectively or retrospectively through utilization review; and with 28 TAC §134.600, which sets out the procedures for preauthorization and retrospective review of professional services, such as those in dispute here. DWC concludes that TLC §413.014 and 28 TAC §134.600 take precedence over the Medicare MUE process. Therefore, the insurance carrier's denial reasons are not supported.

2. As noted above, each of the codes in dispute are timed procedures. In its position statement, the respondent argued, "Documentation submitted for the HCP's initial billing and request for reconsideration does not support a total of 20 hours of testing and interpretation for the **one** date of service billed."

   The NCCI Policy Manual, Chapter 11, (M)(2), effective January 1, 2025, 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 Professional* codebook 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.

   The requester noted on the Neuropsychological Examination report that the claimant

underwent a total of 20 hours of testing, evaluation, and examination services and billed for those services with date of service April 8, 2025.

DWC finds that the requester did not bill in accordance with the *NCCI Policy Manual*, Chapter 11, (M)(2), because "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 report does not list the start and end time of timed procedure codes 96121, 96133, and 96137 to support the number of hours billed. The insurance carrier's position is supported. The requester does not support the request for additional reimbursement for codes 96121-59, 96133-59, and 96137-59.

3. The requester seeks additional payment for codes 96116 and 96132-59. Per 28 TAC §134.203(c)(1), "…To determine to MAR for professional services, system participants shall apply the Medicare payment policies with minimal modification…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 $53.68…"

   The following formula represents the calculation of the maximum allowable reimbursement (MAR) at §134.203 (c)(1) & (2). (DWC Conversion Factor / Medicare Conversion Factor) x Medicare Participating Amount = MAR. In this instance,

   - The DWC conversion factor for 2025 is 70.18.
   - The Medicare conversion factor for 2025 is 32.3465.
   - Per the submitted medical bills, the service was rendered in zip code 78752 which is in Medicare locality 0441231.
   - The Medicare participating amount for CPT code 96116 is $89.64.
   - The Medicare participating amount for CPT code 96132 is $126.70.

   The MAR is calculated as follows:

   - 96116: (70.18/34.6062) x $89.64 = $194.49
   - 96132-59: (70.18/32.3465) x $126.70 = $274.89

   The total allowable for the services in question is $469.38. The insurance carrier paid this amount in full. No additional reimbursement is recommended.

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 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August 22, 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. 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.

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 electronico CompConnection@tdi.texas.gov.