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

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Alison Walls PSYD

Respondent Name
Everest Premier Insurance Co

Carrier's Austin Representative
Box Number 19

MFDR Tracking Number
M4-25-3421-01

DWC Date Received
August 27, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 30, 2025	96116	$0.00	$0.00
January 30, 2025	96132-59-95	$0.00	$0.00
January 30, 2025	96136-59-95	$0.00	$0.00
January 30, 2025	96137-59-95	$0.00	$0.00
February 7, 2025	96133-59-95	$2725.24	$0.00
	Total	$2,725.24	$0.00

Requestor's Position

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

Supplemental response submitted September 30, 2025

"Payment has not been received."

Amount in Dispute: $2,725.24

Respondent's Position

"The current dispute involves HCPCS code 96133-59-95 with date of service of 02/07/2025. Amount in dispute is $2,725.24. Carrier has referred the bill for further consideration and will supplement this response when received."

Response submitted by: Flahive, Ogden & Latson

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 fee guidelines for outpatient hospital services.

Denial Reasons

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

- 05 (97) – The value of the service or procedure is included in the value of another procedure performed on this date.
- OP (B15) – A primary procedure has not been billed and/or recommended for payment. A chare for an add-on procedure cannot be paid.
- @F (W3) – Additional payment made on appeal/reconsideration
- UY (151) – The number of units billed for this procedure code exceeds the reasonable number usually provided in a given setting as defined within the Medically Unlikely Edits (MUEs) which is published and maintained by the Centers for Medicare and Medicaid Services. The provider's charge was grated an allowance up to the MUE value.

Issues

1. Is the insurance carrier's denial of disputed service supported?
2. Does the submitted documentation support the number of units submitted on the medical bill?
3. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $2,725.24 for professional medical services rendered on February 7, 2025. The respondent denied this claim line based on Medicare's MUE values.

   To determine if the respondent's reduction is supported, the DWC refers to the fee guideline for disputed services found at 28 TAC§134.203.

   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."

   The respondent's position statement refers to a Medicare payment policy regarding Medically Unlikely Edit (MUE). 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 position statement based on MUE is not supported.

2. The requester indicates additional reimbursement is requested for the following codes.
   - 96133-59-95 - 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)

The submitted medical bill indicates for code 96133, the number of units as fourteen. 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."

The requestor noted on the Psychological Evaluation Report that the claimant underwent a total of 21 hours of examination and testing on the disputed dates of service. The report indicates.

- 96116 – January 30, 2025 - 1 hour.
- 96136 / 96137 – January 30, 2025 2 hours (1 unit 96136 + 3 units 96137), February 7, 2025, 3 hours, (6 units 96137)
- 96132/96133 – First hour (96132) and additional hours 96133)
- Date of Service: 01/30/2025: 1 hour (96132)
- 2/7/2025: 8 hours (96133)
- 2/18/2024 [sic]: 6 hours (96133)

Because these are time-based codes, the medical record documentation should contain the total time spent rendering and interpreting the service, including the stop and start time of test.

The report does not list the start and end time to support the number of hours billed. The requestor has not supported their request for additional reimbursement of code 96133.

3. The number of units submitted on the medical bill was not supported by the documentation included in this review. No additional reimbursement 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 Alison Walls PSYD 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

_____		October 21, 2025
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.