TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name
Tara Chace, PhD

Respondent Name
Texas Mutual Insurance Co.

MFDR Tracking Number
M4-25-0040-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
September 4, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 19, 2024	90791	$0.00	$0.00
	96132	$275.00	$266.45
	96133	$5,400.00	$0.00
	96136	$125.00	$85.66
	96137	$3,375.00	$0.00
	Total	$9,175.00	$352.11

Requester's Position

The submitted documentation does not include a position statement from the Requester. Accordingly, this decision is based on the information available at the time of adjudication.

Amount in Dispute: $9,175.00

Respondent's Position

"Texas Mutual denied CPT time-based codes 96132, 96133, 96136, & 96137 due to insufficient documentation which did not list a start and end time for each element of testing. Upon review of the medical record for date of service 3/19/25, the documentation did not contain the required detail for time-based codes to support a time-based coding selection."

Response Submitted by: Texas Mutual

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.
- 16 – CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S) WHICH IS NEEDED FOR ADJUDICATION.
- 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEJNG BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.
- 892 - DENIED IN ACCORDANCE WITH DWC RULES AND/OR MEDICAL FEE GUIDELINE INCLUDING CURRENT CPT CODE DESCRIPTIONS/INSTRUCTIONS.
- 18 & 24 – EXACT DUPLICATE CLAIM/SERVICE; DUPLICATE CHARGE.

Issues

1. What procedure codes will be considered in this medical fee dispute resolution (MFDR) 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 96132, 96133, 96136 and 96137?
4. Is the requester entitled to additional reimbursement?

Findings

1. The requester submitted this medical fee dispute resolution (MFDR) request in accordance with 28 TAC §133.307. A review of the DWC060 Medical Fee Dispute Resolution (MFDR) Request form finds that the amount in dispute for CPT code 90791 is $0.00. Consequently, CPT code 90791 will not be considered in the review of this MFDR request.

The procedure codes to be considered in this MFDR review are 96132, 96133, 96136, and 96137.

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 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 $275.00 for one unit of CPT code 96132 and additionally billed $5,400.00 for 24 units of CPT code 96133.

The insurance carrier allowed $0.00 for one unit of CPT code 96132 and allowed $0.00 for 24 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 $125.00 for one unit of CPT code 96136 and additionally charged $3,375.00 for 27 units of CPT code 96137.

The insurance carrier allowed $0.00 for CPT code 96136 and allowed $0.00 for 27 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 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.

4. The requester is seeking reimbursement in the amount of $9,175.00 for services rendered on March 19, 2025. As established in previous findings, the procedure codes to be reviewed and adjudicated for reimbursement due are CPT codes 96132 and 96136.

   To determine the MAR, the following formula is used:
   (DWC Conversion Factor/Medicare Conversion Factor) x Medicare Participating Amount.

   - The rendering date of service is March 19, 2025.
   - The DWC conversion factor for 2025 is 70.18.

- The Medicare conversion factor for the disputed date of service is 32.3465.
- Per the submitted medical bills, the service was rendered in zip code 75702 which is in Medicare locality 99, "Rest of Texas."

CPT code 96132

- The Medicare participating amount in 2025 for CPT code 96132 is $122.81.
- Using the formula above, the MAR is $266.45.
- The insurance carrier paid $0.00.
- Reimbursement in the amount of $266.45 is recommended.

CPT code 96136

- The Medicare participating amount in 2025 for CPT code 96136 is $39.48.
- Using the formula above, the MAR is $85.66.
- The insurance carrier paid $0.00.
- Reimbursement in the amount of $85.66 is recommended.

DWC finds that the requester is entitled to reimbursement in the total amount of $352.11 for the disputed CPT codes 96132 and 96136 rendered on March 19, 2025.

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 established that reimbursement is due in the amount of $352.11.

Order

Under Texas Labor Code §§413.031, the DWC has determined the requester is entitled to reimbursement for the disputed services. It is ordered that Texas Mutual must remit to Tara Chace, PhD, $352.11 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 24, 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.