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

General Information

Requester Name
Gabriel Jasso, PSYD

Respondent Name
TASB Risk Management Fund

MFDR Tracking Number
M4-26-0447-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
October 15, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 3, 2025	96116	$7.50	$0.00
	96121-59	$15.24	$0.00
	96132-59	$10.83	$0.00
	96133-59	$83.04	$0.00
	96136-59	$4.33	$0.00
	96137-59	$44.46	$0.00
	Total	$165.40	$0.00

Requester's Position

"RATES SET BY TDI AND BILL NOT PROPERLY PAID. MEDICALLY REASONABLE HEALTHCARE IS NOT LIMITED DUE TO LABOR CODE."

Amount in Dispute: $165.40

Respondent's Position

"Standing on Texas Fee Schedule payment of $4,378.38 previously issued under TSTX-... under reconsideration bill TSTX-... No additional issued. The professional fee schedule amount for each CPT was derived by using the states custom conversion factor then by the units billed for a total

fee allowance. This payment has been processed in accordance with the Medical Fee Dispute Resolution findings. The check will be issued according to our standard payment schedule."

Response Submitted by: Enlyte

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 §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.

Adjustment Reasons

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

- 350 - BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- 95 - PLAN PROCEDURES NOT FOLLOWED.
- G15 - PRICING IS CALCULATED BASED ON THE MEDICAL PROFESSIONAL FEE SCHEDULE VALUE.
- P12 - WORKERS' COMPENSATION JURJSDICTIONAL FEE SCHEDULE ADJUSTMENT.
- U00 - THERE WAS NO UR PROCEDURE/TREATMENT REQUEST RECEIVED.
- W3 - IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

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. A review of the submitted documentation finds an explanation of benefits (EOB) with a finalized date of October 22, 2025, in which the following reimbursements were allowed for the disputed services:

   - 96116 reimbursement allowed is $188.84 out of $196.34 charged
   - 96121-59 reimbursement allowed is $467.34 out of $482.58 charged
   - 96132-59 reimbursement allowed is $266.45 out of $277.28 charged
   - 96133-59 reimbursement allowed is $2,390.28 out of $2,473.32 charged
   - 96136-59 reimbursement allowed is $85.66 out of $89.99 charged
   - 96137-59 reimbursement allowed is $979.81 out of $1,024.27 charged

   Per the EOB submitted, DWC finds that reimbursements were allowed in the total amount of $4,378.38 for the services in dispute.

2. The procedure codes in question are considered professional medical services. DWC will review these services for additional 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 $196.34 for one unit of procedure code 96116. They additionally billed $482.58 for three units of timed add-on code 96121 with modifier 59.

The insurance carrier allowed $188.84 for one unit of CPT code 96116 and allowed $467.34 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 $277.28 for one unit of CPT code 96132 and additionally billed $2,473.32 for 12 units of CPT code 96133.

   The insurance carrier allowed $266.45 for one unit of CPT code 96132 and allowed $2,390.28

for 12 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 $89.99 for one unit of CPT code 96136 and additionally charged $1,024.27 for 13 units of CPT code 96137.

The insurance carrier allowed $85.66 for CPT code 96136 and allowed $979.81 for 13 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 $165.40 for services rendered on July 3, 2025. 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:
   (DWC Conversion Factor/Medicare Conversion Factor) x Medicare Participating Amount.

   - The rendering date of service is July 3, 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 79761 which is in Medicare locality 99, "Rest of Texas."

CPT code 96116

- The Medicare participating amount for CPT code 96116 is $87.04.
- Using the formula above, the MAR is $188.84.
- The insurance carrier paid $188.84.
- Additional reimbursement is not recommended.

CPT code 96132

- The Medicare participating amount for CPT code 96132 is $122.81.
- Using the formula above, the MAR is $266.45.
- The insurance carrier paid $266.45.
- Additional reimbursement is not recommended.

CPT code 96136

- The Medicare participating amount for CPT code 96136 is $39.48.
- Using the formula above, the MAR is $85.66.
- The insurance carrier paid $85.66.
- Additional reimbursement is not recommended.

DWC finds that the requester is not entitled to additional reimbursement for the disputed services rendered on July 3, 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 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

		December 16, 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 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.