



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Alison Walls PSYD

Respondent Name

Old Republic

MFDR Tracking Number

M4-26-1058-01

Insurance Carrier's Austin Representative

BOX 44 White Espey PLLC

DWC Date Received

December 10, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
April 9, 2025	96116-95	\$2.81	\$0.00
April 9, 2025	96132-59-95	\$3.97	\$0.00
April 9, 2025	96133-59-95	\$1454.60	\$0.00
April 9, 2025	96136-59-95	\$1.06	\$0.00
April 9, 2025	96137-59-95	\$2.79	\$0.00
Total		\$1465.23	\$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: \$1465.23

Respondent's Position

...the Carrier has reviewed the documentation and contends the Provider has been appropriately reimbursed at the appropriate fee schedule reimbursement for the services per the applicable Medicare edits and Division fee schedule.

Response Submitted By: Constitution State Services

Findings and Decision

Authority

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

Statutes and Rules

1. 28 Texas Administrative Code (TAC) Section [133.307](#) sets out the procedures for resolving medical fee disputes.
2. 28 TAC Section [134.203](#) sets out the fee guidelines for professional medical services.

Adjustment Reasons

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 309 – The charge for this procedure exceeds the fee schedule allowance.
- 3244 – The billing of the procedure code has exceeded the National Correct Coding Initiative Medically Unlikely edits amount for the number of times this procedure can be billed on a date of service. An allowance has not been paid.
- 3247 - The billing of the procedure code has exceeded the National Correct Coding Initiative Medically Unlikely edits amount for the number of times this procedure can be billed on a date of service. The correct use of a modifier to report the same code on a separate line permits an additional unit of service to be allowed. Since the modifier has not been used correctly, an additional unit cannot be paid.

Issues

1. What is DWC considering in this medical fee dispute?
2. What rule is applicable to fee guideline calculation?
3. Did the submitted documentation support the number of units submit on the medical bill.
4. Is the requester entitled to additional reimbursement?

Findings

1. The requester is seeking additional reimbursement for professional medical services

rendered in April of 2025. The insurance made reductions based on workers' compensation fee schedule and Medicare payment policies. The amount in dispute is \$1465.23

2. 28 TAC §134.203 (c) (1)(2) states in pertinent part,
 - (c) To determine the Maximum Allowable Reimbursement (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..."

To determine the MAR the following formula is used:

$(\text{DWC Conversion Factor} / \text{Medicare Conversion Factor}) \times \text{Medicare Payment} = \text{MAR}$.

- The CMS physician fee schedule rates are published by carrier and locality.
 - Disputed service was rendered in zip code 75247, locality 04412 11, (Dallas).
 - The disputed date of service is April 9, 2025.
 - The 2025 DWC Conversion Factor is 70.18.
 - The 2025 Medicare Conversion Factor is 32.3465.
 - $96116 - 70.18 / 32.3465 \times \$89.20 = \$193.53$. Carrier paid \$193.53. No additional payment due.
 - $96132 - 70.18 / 32.3465 \times \$125.97 = \$273.31$. Carrier paid \$273.31. No additional payment due.
 - $96136 - 70.18 / 32.3465 \times \$40.99 = \$88.93$. Carrier paid \$88.93. No additional payment due.
3. The insurance carrier reduced the paid amount for the following codes.
 - 96137-59-95 - 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 (List separately in addition to code for primary procedure)
 - 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 reduction for code 96137 was based on the Workers' Compensation State Fee Schedule Adj, and the reduction of code 96133 was based on Medical Unlikely Edit: DOS exceeds MUE value.

28 TAC Section 134.203(b)(1) states.

(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.

28 TAC Section 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 Medicare payment policy regarding Medically Unlikely Edit (MUE) 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 reduction based on MUE is not supported. The application of Division specific guidelines is shown below.

The submitted medical bill indicates code 96133, the number of units as fourteen and code 96137 as nine.

As stated above, 28 TAC Section 134.203(b)(1) states, (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.

The Medicare National Correct Coding Initiative Policy Manual Chapter XI , Section M at <https://www.cms.gov/files/document/11-chapter11-ncci-medicare-policy-manual-2025finalcleanpdf.pdf> states, 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.

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 or that the services were distinct of the other services rendered. The requester has not supported their request for additional reimbursement of code 96133 and 96137.

4. Based on this review, DWC finds the carrier has paid per applicable fee guidelines and no additional payment is due.

Conclusion

The outcome of this medical fee dispute is based on the evidence requester and the respondent presented 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 Sections [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

January 21, 2026
Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC Section [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 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 this *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC Section [141.1\(d\)](#).

Si prefiere hablar con una persona en español acerca de esta correspondencia, favor de llamar a 800-252-7031, opción tres o correo electrónico CompConnection@tdi.texas.gov.