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
Sentinel Insurance Company Ltd

MFDR Tracking Number
M4-26-1102-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
December 12, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 23, 2025	96116	$0.03	$0.00
July 23, 2025	96121-59	$0.03	$0.00
July 23, 2025	96132-59	$0.04	$0.00
July 23, 2025	96133-59	$1030.83	$0.00
July 23, 2025	96136-59	$0.02	$0.00
July 23, 2025	96137-59	$157.69	$0.00
	Total	$1188.70	$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: $1,188.70

Respondent's Position

"After further review of the documentation submitted with this dispute, there is no additional amount warranted."

Response submitted by: The Hartford

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

2. 28 TAC 134.203 sets out reimbursement guidelines for professional medical services.

Denial Reasons

The insurance carrier reduced the disputed service(s) with the following claim adjustment codes.

- 309 – The charge for this procedure exceeds the fee schedule allowance.
- P12 – Workers' compensation jurisdictional fee schedule allowance.
- 1115 – We find the original review to be accurate and are unable to recommend any additional allowance.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.
- 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.

Issues

1. What rule is applicable to reimbursement?
2. Did the requester support the number of units of disputed service?
3. Is the requester due additional reimbursement?

Findings

1. The requestor is seeking reimbursement of professional medical services rendered on July 23, 2025. The applicable fee guideline for the disputed services is found in DWC Rule28 TAC §134.203 (c) (1)(2) which 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:
(DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = MAR.

- The CMS physician fee schedule rates are published by carrier and locality.
- Disputed service was rendered in zip code 77042, locality 04412 18, Houston.
- The disputed date of service is July 24, 2025.
- The 2025 DWC Conversion Factor is 70.18.
- The 2025 Medicare Conversion Factor is 32.3465.
- 70.18/32.3465 x 90.48 (96116) = $196.31. Carrier paid $196.31. No additional payment is recommended.
- 70.18/32.3465 x 73.34 (96121) $74.13 x 3 = $482.50. Carrier paid $482.49. No additional payment is recommended.
- 70.18/32.3465 x 127.27 (96132) = $276.13. Carrier paid $277.24. No additional payment is recommended.
- 70.18/32.3465 x 41.47 (96136) $89.97. Carrier paid $89.97. No additional payment is recommended.

2. The insurance carrier reduced the paid amount for the following codes.
   - 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 (List separately in addition to code for primary procedure)
   - 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 (List separately in addition to code for primary procedure)

The reduction for of these disputed codes were based on Medical Unlikely Edits.

DWC Rule 28 TAC §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.

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 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 respondent's position statement 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 twelve and code 96137 as thirteen.

As stated above, 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 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 requestor has not supported their request for additional reimbursement of code 96133 and 96137.

3. Based on this review, DWC finds no additional payment is due.

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

Signature	Medical Fee Dispute Resolution Officer	January 2, 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 §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.