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

Alaska National Insurance Co.

MFDR Tracking Number

M4-26-2177-01

Insurance Carrier's Austin Representative

BOX 17 Downs Stanford PC

DWC Date Received

April 3, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
October 15, 2025	96116	$7.50	$0.00
October 15, 2025	96121-59	$15.24	$0.00
October 15, 2025	96132-59	$10.83	$0.00
October 15, 2025	96133-59	$1082.92	$0.00
October 15, 2025	96136-59	$4.33	$0.00
October 15, 2025	96137-59	$194.99	$0.00
	Total	$1311.87	$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: $1,311.87

Respondent's Position

"Documentation submitted for the HCP's initial billing and request for reconsideration does not support a total of 20 hours of testing and interpretation for the one date of service billed."

Response Submitted By: CorVel

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

The insurance carrier denied payment for the disputed services with the following reasons:

- 59 – Distinct Procedural Service
- RAI – Medical Unlikely Edit; DOS exceeds MUE value
- P13 – Payment reduced/denied based on state WC regs/policies
- P12 – Workers' Compensation State Fee Schedule Adj
- 193 – Original payment decision maintained
- B13 – Payment for service may have been previously paid
- 152 – Information submitted does not support length of svc

Issues

1. What is DWC considering in this medical fee dispute?
2. Is the denial based on MUE values supported?
3. Did the submitted documentation support number of units/spanned dates of service for codes 96133 and 96137?
4. What rule is applicable to reimbursement?
5. Has DWC determined whether requester is due additional reimbursement?

Findings

1. The requester is seeking additional reimbursement in the amount of $1,311.87 for professional medical services rendered on October 15, 2025.

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 of these codes 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 Section 413.014 which requires that all determinations of medical necessity shall be made prospectively or retrospective through utilization review; and with Rule Section 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 Section 413.014 and 28 TAC Section 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.

3. The submitted medical bill indicates code 96133 with a date span of October 15, 2025 – November 5, 2025 and the number of units as twelve. Code 96137 indicates a date span of October 15, 2025 through November 5, 2025 as thirteen units. The medical bill also indicates the 59 modifier which requires, Documentation must support a different session, different procedure… not ordinarily encountered or performed on the same day by the same individual.

   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 in support of the 59 modifier. Additionally, the span dates listed on the written report does not specify the number of hours or units for any date of service other than October 15, 2025.

The requester has not supported their request for additional reimbursement of code 96133 and 96137.

4. 28 TAC Section 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:
   (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 79925, locality 04412 99, (El Paso, Rest of Texas).
   - The disputed date of service is October 15, 2025.
   - The 2025 DWC Conversion Factor is 70.18.
   - The 2025 Medicare Conversion Factor is 32.3465.
   - 96116 – 70.18/32.3465 x $87.04 = $188.84. Carrier paid $188.84. No additional payment due.
   - 96121 – 70.18/32.3465 x $71.80 = $155.78 x 3 = $467.34. Carrier paid $467.34. No additional payment due.
   - 96132 – 70.18/32.3465 x $122.81 = $266.45. Carrier paid $266.45. No additional payment due.
   - 96136 – 70.18/32.3465 x $39.48 = $85.66. Carrier paid $85.66. No additional payment due.
5. Based on the information available at the time of this review, DWC finds while the insurance carriers reduction based on Medicare MUE is in conflict with DWC rules and Texas Labor Code, the requester did not support the number of units submitted for codes 96133 and 96137 with a date span listing of October 15, 2025 through November 5, 2025. The remaining services were paid at MAR, no additional payment is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence the 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 additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 4, 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 electronico CompConnection@tdi.texas.gov.