TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Alison Wallis PHD

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-23-2489-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
May 27, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 17, 2022	90791	$0.00	$0.00
December 17, 2022	96130	$0.00	$0.00
December 17, 2022	96131	$114.66	$0.00
December 17, 2022	96136	$0.00	$0.00
December 17, 2022	96137	$0.00	$0.00
	Total	$114.66	$0.00

Requestor's Position

"The carrier has not paid in accordance and compliance with TDI-DWC Rule 133 and 134."

Amount in Dispute: $114.66

Respondent's Position

"Payment for CPT code 96131 was made according to Texas Medical Fee Guideline for provider zip code 79925 which is Medicare Region TX99. The Medicare Conversion Factor /CF Anes is $34.6062/$20.84 with a Medicare markup of 1.8049. Our position is that no payment is due."

Response submitted by: Texas Mutual

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 §133.307 sets out the guidelines for the resolution of medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.

Denial Reasons

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

- P12 – Workers compensation jurisdictional fee schedule adjustment
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

1. What is the rule applicable to reimbursement?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for psychological testing rendered in December 2022. The carrier reduced the allowed amount based on the workers compensation fee schedule.

   DWC 28 TAC §134.203 (c)(1) & (2) states in pertinent parts, to determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. For service categories of Physical Medicine and Rehabilitation, when performed in an office setting, the established conversion factor to be applied is date of service annual conversion factors. 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.

The following formula represents the calculation of the DWC MAR at §134.203 (c)(1) & (2).

(DWC Conversion Factor ÷ Medicare Conversion Factor) x Medicare Payment = MAR
or 62.46/34.6062 x $88.15 (location El Paso Texas) x 13 = $2,068.30

2. The total allowable DWC fee guideline reimbursement is $2,068.30. The insurance carrier paid $2,068.30. No additional payment is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has not established payment is due. The amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 29, 2023 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.