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

Requester Name
Alison Walls PSYD

Respondent Name
Texas Mutual Insurance Co

Carrier's Austin Representative
Box Number 54

MFDR Tracking Number
M4-26-1059-01

DWC Date Received
December 10, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 5, 2025	96116-59	$7.50	$0.00
June 5, 2025	96132-59-95	$10.83	$0.00
June 5, 2025	96133-59-95	$103.80	$0.00
June 5, 2025	96136-59-95	$4.33	$0.00
June 5, 2025	96137-59-95	$30.78	$0.00
	Total	$157.24	$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: $157.24

Respondent's Position

"This bill was processed per 2025 physician fee schedules. Our position is that not payment is due."

Response submitted by: Texas Mutual Insurance.

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 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203 sets out the fee guidelines for outpatient hospital services.

Denial Reasons

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

- CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
- G15 – Pricing is calculated based on the medical professional fee schedule value.
- 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.

Issues

1. What rule is applicable to fee guideline calculation?
2. Is the requester entitled to additional reimbursement?

Findings

1. The requester is seeking medical fee dispute resolution in the amount of $157.24 for professional medical services rendered in June of 2025.

DWC Rule 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:
(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 78228, locality 04412 99, Rest of Texas (San Antonio).
- The disputed date of service is June 5, 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.
- 96132– 70.18/32.3465 x $122.81 = $266.45. Carrier paid $266.45. No additional payment due.
- 96133– 70.18/32.3465 x $91.81 x 15 = $2987.91. Carrier paid $2987.85. No additional payment due.
- 96136 - 70.18/32.3465 x $39.48 = $85.66. Carrier paid $85.66. No additional payment due.
- 96137 - 70.18/32.3465 X $34.74 X 9 = $678.36. Carrier paid $678.33. No additional payment due.

2. 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 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 Alison Walls PSYD 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 29, 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 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.