



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Alison Walls PSYD

Respondent Name

Liberty Mutual Fire Insurance Company

MFDR Tracking Number

M4-26-1057-01

Insurance Carrier's Austin Representative

BOX 60 Downs Stanford PC

DWC Date Received

December 10, 2025

Summary of Findings

| Date(s) of Service | Disputed Services | Amount in Dispute | Amount Due |
|--------------------|-------------------|-------------------|---------------|
| June 9, 2025 | 90791-95 | \$12.15 | \$0.00 |
| June 9, 2025 | 96130-59-95 | \$10.72 | \$0.00 |
| June 9, 2025 | 96131-59-95 | \$61.27 | \$0.00 |
| June 9, 2025 | 96136-59-95 | \$4.33 | \$0.00 |
| June 9, 2025 | 96137-59-95 | \$23.94 | \$0.00 |
| Total | | \$112.41 | \$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: \$112.41

Respondent's Position

"We have again reviewed payment for the services of June 09, 2025, by Dr. Alison Walls and determined that reimbursement was issued according to the guidelines provided by the Texas Medical Fee Schedule. No additional payment is due.

Response Submitted By: Liberty Mutual Insurance

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

- 16 – Claim/service lacks information or has submission/billing error(s).
- 3452 -Modifier 95-Synchronous telemedicine service rendered via real-time interactive audio and video telecommunications system.
- 309 – The charge for this procedure exceeds the fee schedule allowance.

Issues

1. What is DWC considering in this medical fee dispute?
2. Is the requester entitled to additional reimbursement for services in question?
3. Is the requester entitled to additional payment?

Findings

1. The requestor is seeking reimbursement of professional medical services rendered on June 9, 2025. The carrier reduced the payment amount amounts based on fee schedule. The supported amount of payment is \$3,171.25. The amount that remains in dispute is \$112.41.
2. The applicable fee guideline for the disputed services is found in 28 TAC Section 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:

$(\text{DWC Conversion Factor} / \text{Medicare Conversion Factor}) \times \text{Medicare Payment for location where services are rendered} = \text{MAR}$.

- The CMS physician fee schedule rates are published by carrier and locality.
 - Disputed service was rendered in zip code 78550, locality 04412 99, Rest of Texas (Harlingen).
 - The disputed date of service June 9, 2025.
 - The 2025 DWC Conversion Factor is 70.18.
 - The 2025 Medicare Conversion Factor is 32.3465.
 - $70.18 / 32.3465 \times 164.52$ (90791) = \$356.95. The carrier paid \$356.95.
 - $70.18 / 32.3465 \times 115.47$ (96130) = \$250.53. The carrier paid \$250.53.
 - $70.18 / 32.3465 \times 81.73$ (96131) = \$177.32 x 11 = \$1,950.56. The carrier paid \$1,950.52.
 - $70.18 / 32.3465 \times 39.48$ (96136) = \$85.66. The carrier paid \$85.66.
 - $70.18 / 32.3465 \times 34.74$ (96137) = \$527.61. The carrier paid \$527.59..
3. Review of the information available at the time of this review found the insurance carrier paid the MAR for the disputed codes 90791 -95, 96131-59-95, 96136-59 -95, 96137 -59 -95, 96130 -59 -95. No additional payment is recommended.

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. Click or tap here to enter text.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

January 14, 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.