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

Liberty Insurance Corporation

MFDR Tracking Number

M4-26-2936-01

Insurance Carrier's Austin Representative

BOX 60 Downs Stanford PC

DWC Date Received

June 15, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
November 1, 2025	96116-95	$7.50	$0.00
November 1, 2025	96132-59-95	$10.83	$0.00
November 1, 2025	96133-59-95	$96.88	$0.00
November 1, 2025	96136-59-95	$4.33	$0.00
November 1, 2025	96137-59-95	$30.78	$0.00
	Total	$150.32	$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: $150.32

Respondent's Position

"We have again reviewed payment for the services of November 01, 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

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:

- Modifier 95-Synchonous telemedicine service rendered via real-time interactive audio and video telecommunications system.
- 309 – The charge for this procedure exceeds the fee schedule allowance.
- 86 – Service performed was distinct or independent from other services performed on the same day.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. What is DWC considering in this medical fee dispute?
2. What rule is applicable to reimbursement?
3. Has DWC determined whether additional reimbursement is due to the requester?

Findings

1. The requester seeks additional reimbursement in the amount of $150.32 for professional medical services provided on November 1, 2025. DWC will review the applicable fee guidelines and determine whether the requester is entitled to additional reimbursement.

2. DWC Rule 28 TAC Section 134.203(c)(1)(2) states, 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) San Antonio TX.
   - The disputed date of service is November 1, 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 = $188.41. Carrier paid $188.84. Zero due.
   - 96132 – 70.18/32.3465 x $122.81 = $265.84. Carrier paid $266.45. Zero due.
   - 96133 – 70.18/32.3465 x $91.81 = $198.73 x 14 = $2,782.28. Carrier paid $2788.66. Zero due.
   - 96136 – 70.18/32.3465 x $39.48 = $85.46. Carrier paid $85.66. Zero due.
   - 96137 – 70.18/32.3465 x $34.74 = $75.20 x 9 = $676.79. Carrier paid $678.33. Zero due.

3. Review of the information available at the time of this review found the insurance carrier made payment per the applicable fee guideline amounts. No additional payment is due.

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	June 23, 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.