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
Gabriel Jasso PSYD

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-25-2945-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
July 18, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 27, 2025	96116	$2.81	$0.00
March 27, 2025	96121 59	$5.22	$0.00
March 27, 2025	96132 59	$3.97	$0.00
March 27, 2025	96133 59	$20.28	$0.00
March 27, 2025	96136 59	$1.06	$0.00
March 27, 2025	96138	$.10	$0.00
March 27, 2025	96139	$.90	$0.00
	Total	$35.27	$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: $35.27

Respondent's Position

"Attached is the original bill we received as well as the EOB showing payment was made per fee schedule. 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 (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203 sets out the reimbursement guidelines for professional medical services.

Denial Reasons

- 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 is the rule applicable to reimbursement?
2. Is the requester entitled to additional reimbursement?

Findings

1. The requester is seeking additional reimbursement for professional medical services rendered in March of 2025. The insurance carrier reduced the billed amount based on fee guidelines.

   The rule applicable to professional medical services is found in DWC Rule 28 Texas Administrative Code §134.203(c)(1) which states, "…To determine to MAR for professional services, system participants shall apply the Medicare payment policies with minimal modification…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 $53.68…"

   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. In this instance,

   - 96116 – CMS Physician fee schedule allowable Dallas, TX $89.20. 70.18/32.3465 x $89.20 = $193.53
   - 96121 59 - $73.34 units 3. 70.18/32.3465 x 73.34 x 3 = $477.36
   - 96132 59 - $125.97. 70.18/32.3465 x 125.97 = $273.31
   - 96133 59 - $94.22 units 12. 70.18/32.3465 x 94.22 x 12 = $2,453.07
   - 96136 59 - $40.99. 70.18/32.3465 x 40.99 = $88.93

- 96138 - $33.83. 70.18/32.3465 x 33.83 = $73.40
- 96139 - $33.83 units 3. 70.18/32.3465 x 33.83 x 3 = $660.59

2. The total allowable DWC fee guideline reimbursement is $4220.19. The insurance carrier paid $4220.17. No additional payment is recommended.

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 requester 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

		September 30, 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.