



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Gabriel Jasso PSYD

Respondent Name

Liberty Mutual Fire Insurance

MFDR Tracking Number

M4-26-0446-01

Carrier's Austin Representative

Box Number 60

DWC Date Received

October 15, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 24, 2025	96116	\$7.50	\$0.00
March 24, 2025	96121-59	\$15.24	\$0.00
March 24, 2025	96132-59	\$10.83	\$0.00
March 24, 2025	96133-59	\$83.04	\$0.00
March 24, 2025	96136-59	\$4.33	\$0.00
March 24, 2025	96137-59	\$44.48	\$0.00
Total		\$165.08	\$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: \$165.08

Respondent's Position

"We base our payments on the Texas Fee Guidelines and the Texas Department of Insurance Division of Workers' Compensation Acts and Rules. This is not a network claim. We have again reviewed payment for the services of March 24, 2025, by Dr. Gabriel Jasso 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 §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 reimbursement guidelines for professional medical services.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- 309 – The charge for this procedure exceeds the fee schedule allowance.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly. Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 86 – Service performed was distinct or independent from other services performed on the same day.

Issues

1. What rule(s) are applicable to disputed services?
2. Is the requester due additional reimbursement?

Findings

1. The requester is seeking additional payment of professional medical services rendered in March of 2025. The insurance carrier reduced the payment stating procedure exceeds fee schedule allowance. DWC Rule 28 Texas Administrative Code §134.203(c)(1)(2) states, The following formula represents the calculation of the DWC MAR at §134.203 (c)(1) & (2).

(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. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007.

(DWC Conversion Factor/Medicare Conversion Factor) x Physician Fee Schedule amount for location = MAR. In this instance,

- DWC Conversion Factor 70.18
 - Medicare Conversion Factor 32.3465
 - Carrier/Location – McAllen (78504) Rest of Texas 04412/99
 - 96116 / 70.18/32.3465 x \$87.04 = \$188.84
 - 96121 / 70.18/32.3465 x \$71.80 x 3 = \$467.34
 - 96132 / 70.18/32.3465 x \$122.81 x 1 = \$266.45
 - 96133 / 70.18/32.3465 x 91.81 x 12 = \$2,390.33
 - 96136 / 70.18/32.3465 x 39.48 x 1 = \$85.66
 - 96137 / 70.18/32.3465 x 34.74 x 13 = \$979.85
 - Total allowable \$4,378.47
2. Review of submitted documentation and applicable fee guidelines indicates the Maximum Allowable Reimbursement is \$4,378.47. The insurance carrier supports payment in the amount of \$4,378.38. No additional payment is recommended. **DWC would like to point out the information beginning on page 48 of the submitted documentation by the requester reflects 2024 DWC Conversion Factors and 2024 CMS Fee Schedule Allowable amounts. The dates of service in dispute are 2025 dates of service therefore, the applicable 2025 amounts are utilized in the calculation of the MAR.**

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

_____	_____	October 23, 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 electrónico CompConnection@tdi.texas.gov.