



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Gabriel Jasso PSYD

Respondent Name

LM Insurance Corp

MFDR Tracking Number

M4-26-0448-01

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
July 24, 2025	96116	\$196.34	\$0.00
July 24, 2025	96121-59	\$196.34	\$0.00
July 24, 2025	96132-59	\$277.28	\$0.00
July 24, 2025	96133-59	\$2473.32	\$0.00
July 24, 2025	96136-59	\$89.99	\$0.00
July 24, 2025	96137-59	\$1024.27	\$0.00
Total		\$4543.78	\$0.00

Requester's Position

"Carrier denied the bill because the doctor is not in network, but this is a designated doctor referred testing and does not need prior approval."

Amount in Dispute: \$4543.78

Respondent's Position

"The bill has been reviewed and adjusted for payment – copies of EOBs are submitted for your review.

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 Texas Administrative Code \(TAC\) §133.307](#) sets out the procedures for resolving medical fee disputes.
2. [28 TAC 134.203](#) sets out reimbursement guidelines for professional medical services.

Denial Reasons

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

- 5884 – Provider is not within the Liberty Health Care Network (HCN) for this customer.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- X598 – Claim has been re-evaluated based on additional documentation submitted; no additional payment due.
- 309 – The charge for this procedure exceeds the fee schedule allowance.
- 86 – Service performed was distinct or independent from other service performed on the same day

Issues

1. What rule is applicable to reimbursement?
2. Is the requester due additional reimbursement?

Findings

1. The requestor is seeking reimbursement of professional medical services rendered on July 24, 2025. The carrier did not maintain their original denial of services and made payment on the disputed charges as follows.
 - 96116 – Billed amount \$196.34. Paid amount \$193.53
 - 96121 -59 3 units – Billed amount \$482.58. Paid amount \$477.36
 - 96132 – Billed amount \$277.28. Paid amount \$273.31
 - 96133 -59 12 units – Bill amount \$2473.32. Paid amount \$2453.04

- 96136 -59 - Billed amount \$89.99. Paid amount \$88.93
- 96137 -59 – Bill amount \$1024.27. Paid amount \$1020.24.

The applicable fee guideline for the disputed services is found in DWC Rule28 TAC §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:

$(\text{DWC Conversion Factor} / \text{Medicare Conversion Factor}) \times \text{Medicare Payment} = \text{MAR}$.

- The CMS physician fee schedule rates are published by carrier and locality.
 - Disputed service was rendered in zip code 75230, locality 04412 11, Dallas.
 - The disputed date of service is July 24, 2025.
 - The 2025 DWC Conversion Factor is 70.18.
 - The 2025 Medicare Conversion Factor is 32.3465.
 - $70.18 / 32.3465 \times 89.20$ (96116) = \$193.53. Carrier paid \$193.53
 - $70.18 / 32.3465 \times 73.34$ (96121) $\$73.34 \times 3 = \477.36 . Carrier paid \$477.36
 - $70.18 / 32.3465 \times 94.22$ (96133) $\$204.42 \times 12 = \$2,453.07$. Carrier paid \$2453.04
 - $70.18 / 32.3465 \times 40.99$ (96136) \$88.93. Carrier paid \$88.93
 - $70.18 / 32.3465 \times 36.17$ (96137) $\times 13 = \$1,020.18$. Carrier paid \$1020.24
 - $70.18 / 32.3465 \times 125.97$ (96132) = \$273.31. Carrier paid \$273.31
 - Total MAR = \$4506.38
2. The total MAR per the applicable fee guideline is \$4506.38. The carrier supports payment in the amount of \$4506.41 on October 22, 2025 with a check reference of 0014332647. 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

_____	_____	December 10, 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.