

Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Gabriel Jasso PSYD

Respondent Name

Employers Insurance Co of Wausau

MFDR Tracking Number

M4-26-1042-01

Carrier's Austin Representative

Box Number 60

DWC Date Received

December 10, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 3, 2025	96116	\$7.50	\$0.00
July 3, 2025	96121-59	\$15.24	\$0.00
July 3, 2025	96132-59	\$10.83	\$0.00
July 3, 2025	96133-59	\$83.04	\$0.00
July 3, 2025	96136-59	\$4.33	\$0.00
July 3, 2025	96137-59	\$44.46	\$0.00
Total		\$165.40	\$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: \$165.40

Respondent's Position

"We have again reviewed payment for the services of July 03, 2025, by Gabriel Jasso PHD 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 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.

- 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 3, 2025. The insurance carrier reduced the billed amount based on fee schedule. The applicable fee guideline for the disputed services is found in DWC Rule 28 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:

(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 79761 (Rest of Texas) Odessa.
- The disputed date of service is July 3, 2025.
- The 2025 DWC Conversion Factor is 70.18.
- The 2025 Medicare Conversion Factor is 32.3465.
- (96116) $70.18/32.3465 \times 87.04 = \188.84 . Carrier paid \$188.84
- (96121) $70.18/32.3465 \times 71.80 \times 3 = \467.34 . Carrier paid \$467.34
- (96132) $70.18/32.3465 \times 122.81 = \266.45 . Carrier paid \$266.45
- (96133) $70.18/32.3465 \times 91.81 = \$199.19 \times 12 = \$2,390.33$. Carrier paid \$2,390.28
- (96136) $70.18/32.3465 \times 39.48 = \85.66 . Carrier paid \$85.66
- (96137) $70.18/32.3465 \times 34.74 = \$75.37 \times 13 = \$979.85$. Carrier paid \$979.81

2. Review of the information available at the time of this review supports the carrier paid the Maximum Allowable Reimbursement (MAR) for the services in dispute. 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 29, 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.