



# Medical Fee Dispute Resolution Findings and Decision

## General Information

**Requester Name**

Gabriel Jasso PSYD

**Respondent Name**

Hartford Ins Co of Illinois

**MFDR Tracking Number**

M4-26-1044-01

**Insurance Carrier's Austin Representative**

BOX 47 Burns Anderson Jury Brenner & Donovan

**DWC Date Received**

December 10, 2025

## Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
April 3, 2025	96116	\$7.50	\$0.00
April 3, 2025	96121-59	\$15.24	\$0.00
April 3, 2025	96132-59	\$10.83	\$0.00
April 3, 2025	96133-59	\$83.04	\$0.00
April 3, 2025	96136-59	\$4.33	\$0.00
April 3, 2025	96137-59	\$44.46	\$0.00
<b>Total</b>		<b>\$165.40</b>	<b>\$0.00</b>

## 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

"As reflected in the EOBs, Hartford Insurance Co of Illinois properly reimbursed Dr. Jasso in accordance with the Texas Workers' Compensation Act and Division Rules and contends that the bill was paid properly per the Texas Worker's Compensation medical fee schedule."

**Response Submitted By:** Burns Anderson Jury & Brenner, L.L.P.

## 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

- 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.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.

### Issues

1. What is DWC considering in this medical fee dispute?
2. What rule is applicable to reimbursement?
3. Is the requester entitled to additional reimbursement?

### Findings

1. The requester seeks additional reimbursement for professional medical services rendered on April 3, 2025. The Carrier reduced the payment amount based on the workers' compensation fee schedule. The carrier has paid \$4,378.38. The requested amount in dispute is \$165.40.
2. The applicable fee guideline for the disputed services is found in 28 TAC Section 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 78550, locality 04412 99, Rest of Texas (Harlingen).
  - The disputed date of service is April 3, 2025.
  - The 2025 DWC Conversion Factor is 70.18.
  - The 2025 Medicare Conversion Factor is 32.3465.
  - $70.18 / 32.3465 \times 87.04$  (96116) = \$188.84. Carrier paid \$188.84.
  - $70.18 / 32.3465 \times 71.80$  (96121) \$155.78 x 3 = \$467.34. Carrier paid \$467.34.
  - $70.18 / 32.3465 \times 122.81$  (96132) = \$266.45. Carrier paid \$266.45.
  - $70.18 / 32.3465 \times 91.81$  (96133) \$199.19 x 12 = \$2,390.33. Carrier paid \$2,390.28.
  - $70.18 / 32.3465 \times 39.48$  (96136) \$85.66. Carrier paid \$85.66.
  - $70.18 / 32.3465 \times 34.74$  (96137) \$75.37 x 13 = \$979.85. Carrier paid \$979.81.
  - Total MAR = \$4,378.47. Carrier paid \$4,378.28.
3. The total MAR per the applicable fee guideline is \$4,378.47. The carrier supports payment in the amount of \$4,378.38. No additional payment is recommended.

### Conclusion

The outcome of this medical fee dispute is based on the evidence 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 reimbursement for the disputed services.

### Authorized Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
January 14, 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](http://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](mailto: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 electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).