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

Requestor Name
Gabriel Jasso PSYD

Respondent Name
Everest Premier Insurance Co

MFDR Tracking Number
M4-26-1047-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
December 10, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 11, 2025	96116	$7.50	$0.00
June 11, 2025	96121-59	$15.24	$0.00
June 11, 2025	93132-59	$10.83	$0.00
June 11, 2025	96133-59	$83.04	$0.00
June 11, 2025	96136-59	$4.33	$0.00
June 11, 2025	96137-59	$8.26	$0.00
	Total	$165.40	$0.00

Requestor'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

"The provider has been reimbursed in accordance with the Medical Fee Guidelines. The provider is not entitled to any additional payment."

Response Submitted by: Flahive, Ogden & Latson

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 fee guidelines for outpatient hospital services.

Denial Reasons

The insurance carrier reduced the payment for the disputed services with the following claim adjustment codes:

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 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.
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3 – Bill is a reconsideration or appeal.

Issues

1. What rule is applicable to reimbursement?

2. Is requester entitled to additional reimbursement?

Findings

1. The requester is seeking additional reimbursement for professional medical services rendered in June of 2025. The insurance carrier reduced the billed amount based on the workers compensation fee schedule. DWC Rule 28 TAC §134.203 (c) (1)(2) 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 79703, locality 04412 99, Rest of Texas (Midland).
- The disputed date of service is June 11, 2025
- The 2025 DWC Conversion Factor is 70.18.
- The 2025 Medicare Conversion Factor is 32.3465.
- 96116 – 70.18/32.3465 x $87.04 = $188.84. The insurance carrier paid $188.84. No additional payment due.
- 96121 - 70.18/32.3465 x 71.80 x $155.78 x 3 = $467.34. The insurance carrier paid $467.34. No additional payment due.
- 96132 – 70.18/32.3465 x $122.81 = $266.45. The insurance carrier paid $266.45. No additional payment due.
- 96133 - 70.18/32.3465 x $91.81 = $199.19 x 12 = $2,390.33. The insurance carrier paid $2390.28. No additional payment due.
- 96136 – 70.18/32.3465 x $39.48 = $85.66. The insurance carrier paid $85.66. No additional payment due.
- 96137 – 70.18/32.3465 x $34.74 = $75.37 x 13 = $979.85. The insurance carrier paid $979.81. No additional payment due.

Review of the information available at the time of this review finds the insurance carrier paid at the fee schedule amount. No additional payment is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor 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 requestor is entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

	Medical Fee Dispute Resolution Officer	January 2, 2026
Signature		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.