



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Gabriel Jasso PSYD

**Respondent Name**

Texas Mutual Insurance Co

**MFDR Tracking Number**

M4-26-1054-01

**Carrier's Austin Representative**

Box Number 54

**DWC Date Received**

December 10, 2025

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 14, 2025	96116	\$7.50	\$0.00
May 14, 2025	96121-59	\$15.24	\$0.00
May 14, 2025	93132-59	\$10.83	\$0.00
May 14, 2025	96133-59	\$83.04	\$0.00
May 14, 2025	96136-59	\$4.33	\$0.00
May 14, 2025	96137-59	\$8.26	\$0.00
May 14, 2025	96138	\$4.53	\$0.00
May 14, 2025	96139	\$40.77	\$0.00
<b>Total</b>		<b>\$176.50</b>	<b>\$0.00</b>

### 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:** \$176.50

### Respondent's Position

"The bill was paid per the physician fee schedule. Our position is that no payment is due."

**Response Submitted by:** Texas 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 fee guidelines for outpatient hospital services.

### Denial Reasons

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

- CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
- G15 – Pricing is calculated based on the medical professional fee schedule value.
- 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.

### 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 May 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:

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

- The CMS physician fee schedule rates are published by carrier and locality.
- Disputed service was rendered in zip code 79925, locality 04412 99, Rest of Texas (El Paso).
- The disputed date of service is May 14, 2025
- The 2025 DWC Conversion Factor is 70.18.
- The 2024 Medicare Conversion Factor is 32.3465.
- $96116 - 70.18 \times 32.3465 \times \$87.04 = \$188.84$ . The insurance carrier paid \$188.84. No additional payment due.
- $96121 - 70.18 \times 32.3465 \times 71.80 \times \$155.78 \times 3 = \$467.34$ . The insurance carrier paid \$467.34. No additional payment due.
- $96132 - 70.18 \times 32.3465 \times \$122.81 = \$266.45$ . The insurance carrier paid \$266.45. No additional payment due.
- $96133 - 70.18 \times 32.3465 \times \$91.81 = \$199.19 \times 12 = \$2,390.33$ . The insurance carrier paid \$2390.28. No additional payment due.
- $96136 - 70.18 \times 32.3465 \times \$39.48 = \$85.66$ . The insurance carrier paid \$85.66. No additional payment due.
- $96137 - 70.18 \times 32.3465 \times \$34.74 = \$75.37 \times 3 = \$226.12$ . The insurance carrier paid \$228.11. No additional payment due.
- $96138 - 70.18 \times 32.3465 \times \$31.79 = \$68.97$ . The insurance carrier paid \$68.97. No additional payment due.
- $96139 - 70.18 \times 32.3465 \times \$31.79 \times 9 = \$620.75$ . The insurance carrier paid \$620.73. No additional payment due.

2. 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**

\_\_\_\_\_  
Signature

Medical Fee Dispute Resolution Officer

December 29, 2025  
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](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 1-800-252-7031, option 3 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 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](mailto:CompConnection@tdi.texas.gov).