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

Requester Name
Gabriel Jasso PSYD

Respondent Name
AIU Insurance Co

MFDR Tracking Number
M4-26-1370-01

Insurance Carrier's Austin Representative
BOX 19 Flahive Ogden & Latson

DWC Date Received
January 15, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
October 9, 2025	96116	$7.50	$0.00
October 9, 2025	96121-59	$15.24	$0.00
October 9, 2025	96132-59	$10.83	$0.00
October 9, 2025	96133-59	$83.04	$0.00
October 9, 2025	96136-59	$4.33	$0.00
October 9, 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

"The carrier's initial EOR recommended payment of $4,378.38. That reimbursement was made pursuant to the Medical Fee Guidelines"

Response Submitted By: Flahive, Ogden & Latson

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

1. 309 – The charge for this procedure exceeds the fee schedule allowance.
2. 86 – Service performed was distinct or independent from other services performed on the same day.
3. P12 – Workers' Compensation Jurisdictional fee schedule adjustment.
4. 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.
5. 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. What is DWC considering in this medical fee dispute?
2. Has the insurance carrier made payment in accordance with applicable fee guideline?
3. Has DWC determined that additional reimbursement is due?

Findings

1. The requester seeks additional reimbursement in the amount of $165.40 for professional medical services rendered in October of 2025. The insurance carrier made reductions based on the workers' compensation fee schedule. The fee calculation based on the applicable DWC rule is below.

2. 28 TAC Section 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 78504, locality 0441299, McAllen (Rest of Texas).
- The disputed date of service is October 9, 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. Carrier paid $188.84. No additional payment due.
- 96121 – 70.18/32.3465 x $71.80 x3 = $467.34. Carrier paid $467.34. No additional payment due.
- 96132 – 70.18/32.3465 x $122.84 = $266.52. Carrier paid $266.45. No additional payment due.
- 96133 – 70.18/32.3465 x $91.81 x12 = $2,390.33. Carrier paid $2,390.28. No additional payment due.
- 96136 – 70.18/32.3465 x $39.48 = $85.65. Carrier paid $85.66. No additional payment due.
- 96137 – 70.18/32.3465 x $34.74 x 13 = $979.85. Carrier paid $979.81. No additional payment due.

3. Review of all the information available at the time of this review, DWC finds the requester is not due additional reimbursement as the payment made by the Carrier was per the applicable fee guideline.

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	February 24, 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. 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.

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 electronico CompConnection@tdi.texas.gov.