



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Gabriel Jasso PSYD

Respondent Name

North Pointe Insurance Co

MFDR Tracking Number

M4-26-2175-01

Insurance Carrier's Austin Representative

BOX 19 Flahive Ogden & Latson

DWC Date Received

April 3, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
September 17, 2025	96116	\$7.50	\$0.00
September 17, 2025	96121-59	\$15.24	\$0.00
September 17, 2025	96132-59	\$10.83	\$0.00
September 17, 2025	96133-59	\$83.04	\$0.00
September 17, 2025	96136-59	\$4.33	\$0.00
September 17, 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 reimbursement amount of \$4,378.38 is based on 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 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

The insurance carrier denied payment for the disputed services with the following reasons:

- 309 – The charge for this procedure exceeds the fee schedule allowance.
- 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.
- 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.

Issues

1. What is DWC considering in this medical fee dispute?
2. What rule is applicable to reimbursement of the disputed charges?
3. Has DWC determined whether the requester is due additional reimbursement?

Findings

1. The requester is seeking additional reimbursement in the amount of \$165.40 for professional medical services rendered on September 17, 2025.
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:

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

- The CMS physician fee schedule rates are published by carrier and locality.
- Disputed service was rendered in zip code 78228, locality 04412, 99-Rest of Texas.
- The disputed date of service is September 17, 2025.
- The 2025 DWC Conversion Factor is 70.18.
- The 2025 Medicare Conversion Factor is 32.3465.
- $96116 - 70.18 / 32.3465 \times \$ = \188.84 . Carrier paid \$188.84 no payment due.
- $96121 - 70.18 / 32.3465 \times \$71.80 = \$155.78 \times 3 = \457.34 . Carrier paid \$467.34.
- $96132 - 70.18 / 32.3465 \times \$122.81 = \$266.45$. Carrier paid \$266.45 no payment due.
- $96133 - 70.18 / 32.3465 \times \$91.81 = 199.19 \times 12 = \2390.33 . Carrier paid \$2390.28 no payment due.
- $96136 - 70.18 / 32.3465 \times \$ = \85.66 . Carrier paid \$85.66 no payment due.
- $96137 - 70.18 / 32.3465 \times \$34.74 = \$75.37 \times 13 = \979.85 . Carrier paid \$979.81 no payment due.

3. Based on the information available at the time of this review, DWC finds the disputed charges were paid at MAR. No additional payment is recommended.

Conclusion

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

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

May 1, 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.