



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Gabriel Jasso PSYD

Respondent Name

TASB Risk Mgmt Fund

MFDR Tracking Number

M4-26-2183-01

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
October 20, 2025	90791-95	\$12.15	\$0.00
October 20, 2025	96130-59-95	\$10.72	\$0.00
October 20, 2025	96131-59-95	\$50.13	\$0.00
October 20, 2025	96136-59-95	\$4.33	\$0.00
October 20, 2025	96137-59-95	\$51.30	\$0.00
Total		\$128.63	\$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: \$128.63

Respondent's Position

"Upon review of the Texas State Fee Guidelines, we have determined no additional payment is warranted. Per the following calculation no additional payment is warranted under Reconsideration bill (redacted) and we are standing on original payment."

Response Submitted By: TASB Risk Fund

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:

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was process properly.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- 351 – No additional reimbursement allowed after review of appeal/reconsideration.
- G15 – Pricing is calculated based on the medical professional fee schedule value.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

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

Findings

1. The requester seeks additional reimbursement in the amount of \$128.63 for professional medical services rendered in October of 2025 via telemedicine.

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 79703, locality 04412 99, Rest of Texas (Midland).
- The disputed date of service is October 20, 2025.
- The 2025 DWC Conversion Factor is 70.18.
- The 2025 Medicare Conversion Factor is 32.3465.
- 90791 -95 – $70.18 / 32.3465 \times \$164.52 = \356.95 . Carrier paid \$356.95 and no additional payment is due.
- 96130 -59 -95 – $70.18 / 32.3465 \times \$115.47 = \250.53 . Carrier paid \$250.53 and no additional payment is due.
- 96131 -59 -95 – $70.18 / 32.3465 \times \$81.73 = \$177.32 \times 9 = \$1,595.92$. Carrier paid \$1,595.88 and no additional payment is due.
- 96136 -59 -95 - $70.18 / 32.3465 \times \$39.48 = \85.66 . Carrier paid \$85.66 and no additional payment is due.
- 96137 -59 -95 – $70.18 / 32.3465 \times \$34.74 = \$75.37 \times 15 = \$1,130.60$. Carrier paid \$1,130.55 and no additional payment is due.

3. Based on the available information at the time of this review, DWC finds the payment made by the insurance carrier was 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

_____	_____	May 7, 2026
Signature	Medical Fee Dispute Resolution Officer	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.