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

Standard Fire Insurance

MFDR Tracking Number

M4-26-2374-01

Insurance Carrier's Austin Representative

BOX 5 Travelers Co Inc

DWC Date Received

April 22, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
February 3, 2026	90791	$13.29	$0.00
February 3, 2026	96130-59	$10.64	$0.00
February 3, 2026	96131-59	$44.03	$0.00
February 3, 2026	96136-59	$6.45	$0.00
February 3, 2026	96137-59	$62.48	$0.00
February 3, 2026	96138-59	$9.31	$0.00
February 3, 2026	96139-59	$97.13	$0.00
	Total	$242.93	$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: $242.93

Respondent's Position

"The Carrier has reviewed the Maximum Allowable Reimbursement Calculation and contends the reimbursement is correct as calculated."

Response Submitted By: Travelers

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 processed properly.
- 947 – Upheld, no additional allowance has been recommended.
- N600 – Adjusted based on the applicable fee schedule for the region in which the service as rendered.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.

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 to the requester?

Findings

1. The requester is seeking additional reimbursement in the amount of $242.93 for professional medical services rendered in February of 2026. The insurance carrier maintains their payment was based on the workers' compensation jurisdictional fee schedule

adjustment. The calculation of the Maximum Allowable Reimbursement (MAR) is shown below.

2. Calculation of the applicable workers' compensation fee schedule for professional medical services is found in DWC Rule 28 TAC Section 134.203(c) which states in pertinent part, 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…"

   The following formula represents the calculation of the DWC MAR at Section 134.203 (c)(1) &(2). DWC Conversion Factor ÷ Medicare Conversion Factor) x Medicare Payment = MAR. In this instance,

   - The 2026 DWC Conversion Factor 72.07
   - The 2026 CMS Conversion Factor 33.4009
   - Zip code 78228 (locality 4412/99 – Rest of Texas) - non-facility
   - 90791 – 72.07/33.4009 x $171.02 = $369.01. Carrier paid $369.01. Zero due.
   - 96130 – 72.07/33.4009 x $121.82 = $262.85. Carrier paid $262.85. Zero due.
   - 96131 – 72.07/33.4009 x $85.42 = $184.31 x 7 = $1,290.19. Carrier paid $1,290.17. Zero due.
   - 96136 – 72.07/33.4009 x $42.43 = $91.55. Carrier paid $91.55. Zero due.
   - 96137 – 72.07/33.4009 x $35.97 = $77.61 x 11 = $853.75. Carrier paid $853.71. Zero due.
   - 96138 – 72.07/33.4009 x $35.80 = $77.25. Carrier paid $77.25. Zero due.
   - 96139 – 72.07/33.4009 x $33.60 = $72.50 x 11 = $797.50. Carrier paid $797.50. Zero due.

3. Based on the information available at the time of this review, no additional reimbursement is due to the requester, as the payment issued by the insurance carrier was consistent with the applicable fee guideline.

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 20, 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.