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

Ace American Insurance Company

MFDR Tracking Number

M4-26-2933-01

Insurance Carrier's Austin Representative

BOX 15 Downs Stanford PC

DWC Date Received

June 15, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
February 18, 2026	96116	$2.55	$0.00
February 18, 2026	96121-59	$7.32	$0.00
February 18, 2026	96132-59	$2.88	$0.00
February 18, 2026	96133-59	$29.47	$0.00
February 18, 2026	96136-59	$6.81	$0.00
February 18, 2026	96137-59	$36.85	$0.00
February 18, 2026	96138-59	$5.41	$0.00
February 18, 2026	96139-59	$60.06	$0.00
	Total	$147.64	$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: $147.64

Respondent's Position

The information from the respondent did not contain a position statement.

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:

- 86 – Service performed was distinct or independent from other services performed on the same day.
- 309 – The charge for this procedure exceeds the fee schedule allowance.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 18 – Exact duplicate claim/service.
- 247 – A payment or denial has already been recommended for this service

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 is seeking additional reimbursement in the amount of $147.64 for professional medical services rendered on February 18, 2026. DWC will review the disputed charges to determine whether additional reimbursement is owed under the applicable statutes and division rules.

2. Review of the submitted medical bill indicates the following codes were submitted 96116, 96121-59, 96132 -59, 96133-59, 96136-59, 96137-59, 96138-59 and 96139-59. The requester has indicated the amount paid is not in accordance with applicable fee guideline.

   28 TAC Section 134.203(c)(1)-(2) provides, in pertinent part, that to determine the Maximum Allowable Reimbursement (MAR) for professional services, system participants shall apply Medicare payment policies with minimal modifications. Specifically:
   1. For service categories including Evaluation and Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery, when performed in an office setting, the applicable conversion factor is $52.83.
   2. The conversion factors identified in paragraph (1) of this subsection are based on the calendar year 2008 conversion factors. For subsequent calendar years, the conversion factors are adjusted by applying the annual percentage change in the Medicare Economic Index (MEI) to the prior year's conversion factors, with the updated conversion factors becoming effective January 1 of each 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 77042, locality 04412 18, Houston.

The disputed date of service is February 18, 2026.

The 2026 DWC Conversion Factor is 72.07.

The 2026 Medicare Conversion Factor is 33.4009.

- 96116 – 72.07/33.4009 x $95.23 = $205.48. Carrier paid $205.48. Zero due.
- 96121 – 72.07/33.4009 x $75.94 = $163.86 x 3 = $491.57. Carrier paid $491.58. Zero due.
- 96132 – 72.07/33.4009 x $123.57 = $266.63. Carrier paid $266.63. Zero due.
- 96133 – 72.07/33.4009 x $98.42 = $212.36 x 7 = $1,486.54. Carrier paid $1,486.52. Zero due.
- 96136 – 72.07/33.4009 x $43.98 = $94.90. Carrier paid $94.90. Zero due.
- 96137 – 72.07/33.4009 x $37.05 = $79.94 x 11 = $879.38. Carrier paid $879.34.
- Zero due.
- 96138 – 72.07/33.4009 x $37.61 = $81.15. Carrier paid $81.15. Zero due.

- 96139 – 72.07/33.4009 x $35.16 = $75.87 x 11 = $834.52. Carrier paid $834.57. Zero due.

3. Based on the information available at the time of this review, DWC finds that the insurance carrier paid the applicable MAR amounts. No additional reimbursement 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

		June 24, 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.