



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Gabriel Jasso PHD

Respondent Name

Zurich American Insurance Co

MFDR Tracking Number

M4-23-2486-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

May 27, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 7, 2022	90837	\$13.01	\$0.00
July 14, 2022	90837	\$13.01	\$0.00
July 21, 2022	90837	\$13.01	\$0.00
July 28, 2022	90837	\$13.01	\$0.00
August 4, 2022	90837	\$13.01	\$0.00
August 11, 2022	90837	\$13.01	\$0.00
Total		\$78.06	\$0.00

Requestor's Position

"The attached claim for work comp treatment and services has been reduced/cut inappropriately based on the MAR for the CPT Codes billed according to DWC rule 133 and 134."

Amount in Dispute: \$78.06

Respondent's Position

"It is the carrier's position that the provider is not entitled to any additional monies. We are attaching a copy of the carrier's calculations. The calculations supports the payment of \$275.50 for each date of service."

Findings and Decision

Authority

This medical fee dispute is decided according to [Texas Labor Code §413.031](#) and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.
2. [28 TAC §134.203](#) sets out the reimbursement guidelines for professional medical services.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- 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. Did the respondent support their position statement?

Findings

1. The requestor is seeking additional payment of professional medical services rendered in 2022. The insurance carrier reduced the billed amount based on the workers' compensation jurisdictional fee schedule. The requestor states the reduction was not per applicable fee guideline.

DWC 28 TAC §134.203 (c)(1) & (2) states in pertinent parts, (c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. For service categories of Physical Medicine and Rehabilitation, when performed in an office setting, the established conversion factor to be applied is date of service annual conversion factors. 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 §134.203 (c)(1) & (2).

(DWC Conversion Factor ÷ Medicare Conversion Factor) x Medicare Payment = MAR

- 62.46/34.6062 x \$152.64 (location Dallas, Texas) = \$275.50 x the six dates of service

equals \$1,653.00

The total allowable DWC fee guideline reimbursement is \$1,653.00. The insurance carrier paid \$1,653.00. The requestor's position is not supported. No additional payment is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent 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 §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

June 26, 2023

Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §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 1-800-252-7031, option 3 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 the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in [28 TAC §141.1\(d\)](#).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electrónico CompConnection@tdi.texas.gov.