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

Requestor Name
CONFIRMATIVE
MANAGEMENT SERVICES

Respondent Name
AMERICAN ZURICH INSURANCE COMPANY

MFDR Tracking Number
M4-23-0243-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
September 28, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 21, 2021	80307 and G0483	$750.00	$0.00
	Total	$750.00	$0.00

Requestor's Position

"DENIAL: This provider was not certified/eligible to be paid for this procedure/service on this date of service. NOT APPROVED PROVIDER."

Amount in Dispute: $750.00

Respondent's Position

"This medical dispute concerns services provided by Confirmative Mgmt Svcs associated with dates of service 10-21-21/10-21-21. Attached is a copy of the DWC 53 approval order dated 6-11-20 supporting our position that the prescribing physician was not an approved provider on the date of service."

Response Submitted by: ESIS

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 Texas Administrative Code (TAC) §133.307, effective May 31, 2012, sets out the procedures for resolving medical fee disputes.
2. Texas Labor Code (TLC) 408.021 sets out the entitlement to medical benefits.

Denial Reasons

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:

- 1- B7 - This provider was not certified/eligible to.be paid for this procedure/service on this date of service. (ANSIB7)
- 2 - NOT APPROVED PROVIDER (NSOl).

Issues

Is the respondent's denial reason supported?

Findings

The requestor seeks reimbursement for CPT/HCPCs codes 80307 and G0483 rendered on October 21, 2021. The insurance carrier denied the disputed service with denial reason codes indicated above.

Texas Labor Code §408.021(c) requires that "Except in an emergency, all health care must be approved or recommended by the employee's treating doctor."

The requestor submitted insufficient documentation to support that the services rendered, were provided by, or recommended by the employee's treating doctor. The DWC finds that the insurance carrier's denial reason is therefore supported. As a result, reimbursement of the d disputed services, cannot be 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.

The DWC finds the requester has not established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 23, 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 electronico CompConnection@tdi.texas.gov.