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
Peak Integrated Healthcare

Respondent Name
Old Republic Insurance Co

MFDR Tracking Number
M4-23-2096-01

Carrier's Austin Representative
Box Number 44

DWC Date Received
April 26, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 2, 2023	99213	$174.71	$0.00
January 2, 2023	99080-73	$15.00	$0.00
	Total	$189.71	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. Rather they submitted a copy of their reconsideration with a hand written note that states, "A payment or denial had not been paid. Please process for payments. Thank you."

Amount in Dispute: $189.71

Respondent's Position

"Supplemental response will be provided once the bill auditing company has finalized their review.

Supplemental response May 15, 2023

"After review, the charges were already processed and payment was issued. Date of Service 01/02/2023, billed Charge $189.72. . . DCN – 2023019DD007454 Date bill received by GB – 01/19/2023 Date bill sent to CVTY – 01/20/2023 Date bill returned to GB -01/24/2023 Allowed amount - $182.22 Payment Date – 01/24/2023 Payment Status – Cleared. Adjusted for reconsideration. DCN – 2023103DD514928 Date bill received by GB – 04/13/2023 Date bill sent to CVTY – 04/17/2023. . . Allowed amount $7.49 Payment Date - 04/24/2023 Payment Status – Cleared."

Response submitted by: Gallagher Bassett

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 billing and coding guidelines for durable medical equipment.

Denial Reasons

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

- 5721 – To avoid duplicate bill denial for all reconsideration/adjustments/additional payment requests, submit a copy of the EOR or clear notation.
- 90202 & B13 – Previously paid payment for this claim/service may have been provided in a previous payment.
- 247 – A payment or denial has already been recommended for this service.
- 90950 – This bill is a reconsideration of a previously reviewed bill. Allowance amounts reflect any changes to the previous amount.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.

- 309 This charge for this procedure exceeds the fee schedule allowance.

Issues

1. Did the respondent support payment was made on the disputed service?

Findings

1. The requestor is seeking reimbursement for CPT cods 99213 and 99080-73, rendered on January 2, 2023 in the amount of $189.71. This respondent provided evidence of a payment of $182.22 made on January 24, 2023 that has cleared and a payment of $7.49 on April 24, 2023 that has cleared. The total amount paid was $189.71.

   The division finds that additional payment is not 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 reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 29, 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.