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
XL Specialty Insurance Co.

MFDR Tracking Number
M4-23-2145-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
May 2, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
11/22/2022	99361-W1	$113.00	$0.00
12/22/2022	99213	$167.22	$0.00
12/22/2022	99080-73	$15.00	$0.00
	Total	$295.22	$0.00

Requestor's Position

"Please see attached. We have not received payment for these dates of service. Please process for payment."
Amount in Dispute: $295.22

Respondent's Supplemental Position

"Carrier has previously responded to this dispute on June 6, 2023. As noted in the carrier's initial response, the provider has already been paid the amount that the provider is claiming. The carrier issued two checks on January 10, 2023. The first check was in the amount of $113. The check number was 657-0449B. A copy of that payment information what included in the carrier's June 6, 2023, response. We are attaching additional documents including proof of payment of the amount of $182.22. It was issued on January 10, 2023. The check number is 6570450B. The two amounts added together total $295.22 which is the amount the provider is claiming on its DWC 60. The provider should withdraw its request for Medical Fee Dispute Resolution on the basis that the amount in dispute was previously paid. Alternatively, the Division should dismiss the provider's request on the basis that the dispute has resolved."
Response Submitted by: Flahive, Ogden & Latson

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 §133.307 sets out the procedures for Medical Fee Dispute Resolution requests.

Adjustment Reasons

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

- IN – REIMBURSEMENT IS BASED UPON BILLED AMOUNT.
- W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- 193 - ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.

Issues

1. Has the requestor been previously paid for the dates of service in dispute?

2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement in the amount of $295.22 for disputed services rendered on November 22, 2022, and December 22, 2022.

Review of submitted documentation finds that the requestor billed the insurance carrier a total amount of $295.22 for services rendered on disputed dates November 22, 2022, and December 22, 2022.

Review of the submitted explanation of benefits (EOB) documents finds the following:

- EOB dated January 10, 2023, allowed reimbursement in the amount of $113.00, with check number 6570449B attached in the allowed amount, for date of service November 22, 2022.
- EOB dated January 10, 2023, allowed reimbursement in the amount of $182.22, with check number 6570450B attached in the allowed amount, for date of service December 22, 2022.

The DWC finds, per EOBs submitted, that the requestor has been previously reimbursed their full charges in the total amount of $295.22, for disputed dates of service November 22, 2022, and December 22, 2022.

2. The insurance carrier has supported by documentation submitted, that it has paid the requestor in full for the disputed dates of service. Therefore, the DWC finds that no additional reimbursement is due.

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 Division finds the requester has not established that additional reimbursement is due.

Order

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

Authorized Signature:

		August 30, 2023
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 §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.tas.gov.