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
Allmerica Financial Alliance Insurance Co

MFDR Tracking Number
M4-23-2159-01

Carrier's Austin Representative
Box Number 1

DWC Date Received
May 3, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 19, 2022	99213	$167.22	$0.00
December 19, 2022	99080-73	$15.00	$0.00
January 3, 2023	99213	$174.71	$0.00
January 3, 2023	99080-73	$15.00	$0.00
	Total	$371.93	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for medical fee dispute but did submit a copy of their reconsideration that has a hand-written note dated May 3, 2023 that states, "We disagree that these office visits exceed the fee schedule. Please process for payment as office visits have been paid on all other d.o.s."

Amount in Dispute: $371.93

Respondent's Position

"After careful review of the submitted documentation from the provider it was determined that both DOS 12/19/22 & 1/03/23 have already been processed and payment issued. Attached are copies of the cashed checks. …At this time, it appears the dispute has been resolved by way of the bill review's that were processed and proof of payments that we have now provided."

Response Submitted by: Medata

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 services.

3. 28 TAC §129.5 sets out the fee guidelines for work status reports.

Denial Reasons

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

- 01P12 – The charge for the procedure exceeds the amount indicated in the fee schedule.
- W3 – No additional reimbursement allowed after review of appeal/reconsideration.
- YO(P12) – Denial after reconsideration.

Issues

1. Did the insurance carrier support payment was made for the billed amount for each disputed date of service?

Findings

1. The requestor is seeking reimbursement for dates of service December 19, 2022 and January 3, 2023 for professional medical services.

   Review of the submitted medical bill for December 19, 2022 found the billed amount was $182.22. The insurance carrier submitted evidence of a payment of $182.22 that was posted January 31, 2023 via check 61029857. The requestor was paid at requested amount. No additional payment is recommended.

   Review of the submitted medical bill for January 3, 2023 found the billed amount was $189.71. The insurance carrier submitted evidence of a payment of $189.71 that was posted on January 31, 2023 via check 61029706. The requested was paid at requested amount. 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 entitled to $0.00. reimbursement for the disputed services.

Authorized Signature

		July 20, 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.texas.gov.