



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

PEAK INTEGRATED
HEALTHCARE

Respondent Name

AMERICAN ZURICH INSURANCE CO

MFDR Tracking Number

M4-23-1855-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

March 29, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 24, 2022	Code 99213 and 99080-73	\$182.22	\$0.00
June 29, 2022	Code 97545-WH and 97546-WH	\$204.80	
July 11, 2022	Code 97545-WH and 97546-WH	\$204.80	
July 20, 2022	Code 97545-WH and 97546-WH	\$76.80	
July 21, 2022	Code 97545-WH and 97546-WH	\$76.80	
July 26, 2022	Code 97545-WH and 97546-WH	\$76.80	
August 01, 2022	Code 97545-WH and 97546-WH	\$204.80	
Total		\$1,027.02	\$0.00

Requestor's Position

"The attached 05/24/, 06/29, 07/11, 08/01 dates of services were never processed or we never received the EOB. I have attached the original claim with the original date that it was sent as well as the patient ledger which is a direct printout from our system showing the date order they were initially sent ... The above 07/20, 07/21, 07/26/2022 dates of service were NOT paid in full. They have been returned due to reasons: 'workers compensation jurisdictional fee adjustment.'"

Amount in Dispute: \$1,027.02

Respondent's Supplemental Position

"Carrier has previously responded to this dispute on April 14, 2023. The carrier has reprocessed the provider's bills. We are attaching the EOBs that recommend 100% of the requested payment. We would ask that once the provider receives payment, that he withdraw his request for medical fee dispute resolution on the basis 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 \(TLC\) §413.031](#) and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

28 Texas Administrative Code (TAC) [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.

Denial Reasons

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

- P13 – Payment reduced or denied based on Workers Compensation Jurisdictional regulations or payment policies, use only if no other code is applicable
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal

Issues

1. What are the services considered in this dispute?
2. Is PEAK INTEGRATED HEALTHCARE entitled to additional reimbursement?

Findings

1. The requestor's DWC060 Medical Fee Dispute Request shows disputed services on dates May 24, June 29, July 11, 20, 21, 26, and August 1, 2022. Per the insurance carrier's response, "The carrier has reprocessed the provider's bills...that recommend 100% of the requested payment." The requestor acknowledged that the disputed amount was paid for all services except for code 99213 for date of service May 24, 2023 stating "date of service 05/24 was not paid in full. They only paid \$15 for the DWC-173." The decision will only address code 99213 for May 24, 2022 with a disputed amount of \$167.22 as both parties acknowledge payment for all other disputed services.

2. The requestor is seeking payment of \$167.22 for the disputed services. Review of the submitted documentation for date of service May 24, 2022 finds the greater weight of evidence supports previous payment made to the requestor for \$167.22 for the May 24, 2022 disputed service.

Therefore, no additional allowance is due for this date of service.

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 requestor is entitled to \$0.00.

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

July 13, 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 three 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 tres o correo electronico CompConnection@tdi.texas.gov.