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
Kelly D. Clenney, D.C.

Respondent Name
American Zurich Insurance Co.

MFDR Tracking Number
M4-24-2622-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
July 30, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 1, 2024	99456-W5	$385.00	$0.00
July 1, 2024	99456-W8	$142.00	$0.00
	Total	$527.00	$0.00

Requestor's Position

Submitted documentation does not include a position statement from the requestor. Accordingly, this decision is based on the information available at the time of adjudication.

Amount in Dispute: $527.00

Respondent's Position

"Following the filing of the DWC 60, the carrier paid an additional $142 under CPT code 99456 W8. However, that still leaves a difference of $385 for the impairment rating portion of the exam. The carrier is reprocessing the provider's bill in case the provider is entitled to additional reimbursement. At the current time, the carrier has paid the provider a total of $1091 of the $1476 bill. The carrier will be supplementing its response if it is paying any additional monies."

Respondent's Supplemental Position

"Carrier has previously responded to this dispute on August 20, 2024. Attached is an EOB recommending payment of an additional $385.00."

Responses 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:

- P12 - WORKPERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- 18 – EXACT DUPLICATE CLAM/SERVICE.
- W3 - IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

1. Have the services in dispute been previously allowed reimbursement?

2. Is the requestor entitled to additional reimbursement?

Finding

1. The requestor is seeking reimbursement in the total amount of $527.00 for disputed services rendered on July 1, 2024.

   A review of the submitted documentation finds that the requestor billed the insurance carrier a total amount of $1,476.00 for designated doctor examination services rendered on July 1, 2024.

   The explanation of benefits (EOB) documents submitted indicates the following reimbursements have been allowed for the services in dispute as of the date of this review:

   - EOB dated July 18, 2024, allowed reimbursement in the amount of $949.00.
   - EOB dated August 6, 2024, allowed an additional reimbursement in the amount of $142.00.
   - EOB dated August 26, 2024, allowed an additional reimbursement in the amount of $385.00.

   A review of the EOBs submitted finds that the designated doctor examination services in dispute, rendered on July 1, 2024, have been allowed reimbursement in the total amount of $1,476.00 as of the date of this review.

2. DWC finds, per the EOBs submitted, that as of the date of this review, the requestor has been allowed reimbursement for charges in full for the disputed date of service July 1, 2024. Therefore, no additional reimbursement 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 requestor 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 additional reimbursement for the disputed services.

Authorized Signature:

December 13, 2024

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.