



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requester Name**

Shannon Clinic

**Respondent Name**

Highlands Insurance Co

**MFDR Tracking Number**

M4-25-1794-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

April 3, 2025

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 2, 2024	99232	\$141.00	\$0.00
August 31, 2024	99232	\$141.00	\$0.00
August 30, 2024	99232	\$141.00	\$0.00
August 29, 2024	99232	\$141.00	\$0.00
August 28, 2024	99232	\$141.00	\$0.00
August 26, 2024	99232	\$141.00	\$0.00
August 22, 2024	99232	\$141.00	\$0.00
August 21, 2024	99232	\$141.00	\$0.00
August 20, 2024	99232	\$141.00	\$0.00
<b>Total</b>		\$1,269.00	\$0.00

### Requester's Position

“(Injured worker) inpatient status at Shannon Hospital was from 8/19/24 thru 9/4/24 and treated by multiple providers. Wound Care Specialist, Internal Medicine, Urology, Infectious Disease, and

a General Surgeon. Shannon Clinic billed physician charges from the multiple providers with different specialties under the same tax id. Sedgwick has denied payments stating these are duplicated charges and denied subsequent appeals. Attempts to resolve this issue have not been successful, with calls to the carrier and adjustor..."

**Amount in Dispute:** \$1,269.00

### **Respondent's Position**

"The carrier has reprocessed the provider's medical bills and has issued checks in the amount of \$1410 plus interest. That is more than what the provider was requesting."

**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

1. [28 Texas Administrative Code \(TAC\) §133.305](#) sets out the procedures for resolving medical disputes.
2. [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:

- 2008 – Additional payment made on appeal/reconsideration.
- 948 – Re-reviewed at providers request with additional information and documentation: Payment suggested.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- W3 – Bill is a reconsideration or appeal.
- 247 – A payment or denial has already been recommended for this service.
- 18 – Exact duplicate claim/service
- 193 – Original payment decision is being maintained.
- 146 – The usual preoperative and postoperative visits are considered inclusive in the value for the anesthesia service.
- 53 – Two evaluations/visits have been inappropriately billed on the same date of service.

- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 814 – Payment denied because only one visit or consultation per physician per day is covered.
- N702 – Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.

### Issues

1. Is the respondent's position statement supported?
2. What services remain in dispute?
3. Did the requester submit the required documentation?

### Findings

1. The respondent states in their response dated April 22, 2025, "The carrier has reprocessed the provider's medical bills and has issued checks in the amount of \$1410 plus interest." Review of the submitted documents found evidence of a payment in the amount of \$564.00 via check number 148582975 on May 9, 2025. This payment was for dates of service August 26, 2024, August 22, 2024, August 21, 2024 and August 20, 2024 each in the amount of \$141.00. The respondent's position is partially supported.
2. Neither party submitted evidence of payment for the remaining balance of \$705.00 for dates of service September 2, 2024, August 31, 2024, August 30, 2024, August 29, 2024 or August 28, 2024. The billed amount for each date of service was \$141.00. These remaining services in dispute are reviewed as follows.
3. DWC Rule 28 TAC 133.307 (J)(K) states in pertinent parts, "The requestor must send the request to the division in the form and manner prescribed by the division..."

(J) a copy of all medical bills related to the dispute, as described in §133.10 of this chapter (concerning Required Billing Forms/Formats) or §133.500 (concerning Electronic Formats for Electronic Medical Bill Processing) as originally submitted to the insurance carrier in accordance with this chapter, and a copy of all medical bills submitted to the insurance carrier for an appeal in accordance with §133.250 of this chapter (concerning Reconsideration for Payment of Medical Bills);

(K) each explanation of benefits or e-remittance (collectively "EOB") related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB;

The request for MFDR submitted by Shannon Medical Clinic did not contain the required medical bills and explanation of benefits for dates of service September 2, 2024, August 31, 2024, August 30, 2024, August 29, 2024 and August 28, 2024. Therefore, these dates of service cannot be reviewed. No payment is recommended.

## Conclusion

Based on the evidence presented by both the requester and respondent at the time of adjudication, and upon review of applicable Texas Workers' Compensation rules and Medicare policies, the Division of Workers' Compensation finds:

- The insurance carrier supports payment in the amount of \$564.00
- The requester did not submit the required medical bills and explanation of benefits as required by Division Rule 133.307 for dates of service listed on DWC60. Specifically, September 2, 2024, August 31, 30, 29, 28, 2024. These services cannot be reviewed at MFDR.

Although not all submitted evidence is discussed in detail, it was fully considered in reaching this determination.

## **Order**

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

## **Authorized Signature**

\_\_\_\_\_  
Signature

Medical Fee Dispute Resolution Officer

July 24, 2025  
\_\_\_\_\_  
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](http://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](mailto: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 electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).