



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Marcus Hayes, D.C.

Respondent Name

National Liability & Fire Insurance Co.

MFDR Tracking Number

M4-25-2753-01

Carrier's Austin Representative

Box Number 6

DWC Date Received

July 1, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 17, 2024, through November 5, 2024	Therapy Services	\$3,790.00	\$0.00

Requester's Position

"I am writing to request an MFDR for the following date of service for date range of 10/17/24-11/05/24 in the amount of \$3790 that we never got paid for. Adjuster stated she sent out the check we never received it and now filing Medical Fee Dispute within timely to get paid."

Amount in Dispute: \$3,790.00

Respondent's Position

Per email correspondence from the insurance carrier representative to the insurance carrier, dated October 6, 2025:

"I am continuing to get requests from the agency and the provider asking that you void the check issued in this case and resend it. Attached is the history of this transaction. Apparently, the

check was # XXXXXXXX in the amount of \$3790 for DOS 10/17 - 11/5/24. I am copying MRD on this email, as well as the provider.”

Response submitted by: Stone Loughlin & Swanson, LLP

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 \(TAC\) §133.307](#) sets out the procedures for Medical Fee Dispute Resolution requests.

Adjustment Reasons

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

- G15 – PRICING IS CALCULATED BASED ON THE MEDICAL PROFESSIONAL FEE SCHEDULE VALUE.
- J16 – THIS PROCEDURE CODE WAS RANKED AS PRIMARY SERVICE WHEN CONSIDERED FOR MULTIPLE PROCEDURE REDUCTION. AS A RESULT, NO REDUCTION WAS TAKEN.
- J31 – THE THERAPY SERVICE CODE HAS BEEN REDUCED PER THE MEDICARE MULTIPLE PROCEDURE RULE FOR THERAPY SERVICES.
- P12 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- P13 – PAYMENT REDUCED OR DENIED BASED ON WORKERS COMPENSATION JURISDICTIONAL REGULATIONS OR PAYMENT POLICIES.
- U03 – THE BILLED SERVICE WAS REVIEWED BY UR AND AUTHORIZED.

Issues

1. Have the disputed services received reimbursement as of the date of this review?
2. Is the requester entitled to additional reimbursement for the services in dispute?

Findings

1. The requester is seeking reimbursement in the amount of \$3,790.00 for therapy services rendered from October 17, 2024, through November 5, 2024.

A review of the submitted explanation of benefits (EOB) dated December 4, 2024, finds that the services in dispute have been allowed reimbursements in the total amount of \$3,791.00 as of the date of this review. DWC finds that the provider’s name and address on the EOB

matches the Billing Provider name and address in field #33 of the CMS 1500 medical billing form.

Per review of the medical bills and EOBs, reimbursement has been allowed in the full amount of charges for the disputed dates of service.

DWC finds that the services in dispute have previously been reimbursed in the total amount of \$3,791.00.

2. The requester is seeking reimbursement in the total amount of \$3,790.00 for therapy services rendered October 17, 2024, through November 5, 2024.

According to the submitted documentation, the insurance carrier has previously allowed reimbursement in the total amount of \$3,791.00 for the dates of service in dispute. Consequently, DWC cannot recommend additional reimbursement.

DWC finds that the requester is not entitled to additional reimbursement for the services in dispute.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requester 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 requester is entitled to reimbursement in the amount of \$0.00 for the disputed dates of service.

Authorized Signature:

December 23, 2025

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, 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 electrónico CompConnection@tdi.tas.gov.