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

Requester Name
Aaron Levine, M.D.

Respondent Name
Insurance Company of the West

MFDR Tracking Number
M4-25-3354-01

Carrier's Austin Representative
Box Number 04

DWC Date Received
August 20, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 18, 2024	Designated Doctor Examination 99456-W5	$128.00	$0.00

Requester's Position

"THE CURRENT RULES ALLOW REIMBURSEMENT"

Amount in Dispute: $128.00

Respondent's Position

"Following re-review, our bill review vendor recommended an additional payment of $128.00 which ICW paid … on 9/3/25."

Response Submitted by: ICWGroup Insurance Companies

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) §133.307 sets out the procedures for resolving medical fee disputes.

Denial Reasons

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

- G15 – Pricing is calculated based on the medical professional fee schedule value.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. Is Aaron Levine, M.D. entitled to additional reimbursement for the examination in question?

Findings

1. Dr. Levine is seeking additional reimbursement for a designated doctor examination performed on November 18, 2024. Per explanation of benefits dated August 24, 2025, the insurance carrier paid the requested amount in full. DWC finds that no additional reimbursement is recommended.

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 $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 20, 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. 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.