



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Auto & Work Injury Clinic-Daniel Beltran

Respondent Name

Zurich American Insurance Company

MFDR Tracking Number

M4-26-1379-01

Insurance Carrier's Austin Representative

BOX 19 Flahive Ogden & Latson

DWC Date Received

January 16, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
November 10, 2025	97799-CP-GP	\$2400.00	\$0.00
Total		\$2400.00	\$0.00

Requester's Position

The requester did not submit a position statement with this request for MFDR. They did submit a document dated December 8, 2025 that states, "Please review the claim, correct the units to reflect the authorized 8 units, and reprocess the claim..."

Amount In Dispute: \$2400.00

Respondent's Position

"Our initial response to the above reference medical fee dispute resolution is as follows: we have escalated the bills in question for manual review to determine if additional monies are owed."

Response Submitted By: Gallagher Bassett

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code Section [413.031](#) and other applicable laws and rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) Section [133.307](#) sets out the procedures for resolving medical fee disputes.
2. 28 TAC [134.600](#) sets out the requirements of prospective and concurrent review of health care.

Adjustment Reasons

- 198 – Pre-authorization/authorization/exceeded
- N54 – Claim information is inconsistent with pre-certified/authorized services.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- XXU05 – The billed service exceeds the UR amount authorized.

Issues

1. What is DWC considering in this medical fee dispute?
2. Is the insurance carrier's denial supported?

Findings

1. The requester is seeking reimbursement of chronic pain management services rendered on November 10, 2025 in the amount of \$2400.00.
2. The insurance carrier denied this date of service as the pre-authorization was exceeded. 28 TAC 134.600(p)(10) states, Non-emergency health care requiring preauthorization includes: chronic pain management/interdisciplinary pain rehabilitation.

Review of the submitted documents found a Texas Utilization Review Approval dated August 1, 2025. The approval indicates Chronic Pain Management 10 visits from July 31, 2025 through October 31, 2025. The disputed date of service is November 10, 2025. The insurance carrier's denial is supported. No payment is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence the requester and the respondent presented at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that reimbursement is due.

Order

Under Texas Labor Code Sections [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

April 14, 2026
Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC Section [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 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 this Medical Fee Dispute Resolution Findings and Decision** with any other required information listed in 28 TAC Section [141.1\(d\)](#).

Si prefiere hablar con una persona en español acerca de esta correspondencia, favor de llamar a 800-252-7031, opción tres o correo electrónico CompConnection@tdi.texas.gov.