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
Bryce Kindley, DC

Respondent Name
American Zurich Insurance Company

MFDR Tracking Number
M4-26-1640-01

Insurance Carrier's Austin Representative
BOX 19 Flahive Ogden & Latson

DWC Date Received
February 10, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
January 7, 2026	99213	$11.11	$0.00
January 7, 2026	99080-73	$0.00	$0.00
	Total	$11.11	$0.00

Requester's Position

The requester did not submit a position statement with this request for MFDR. They did submit a copy of a document titled, "Reconsideration" dated January 26, 2026 and February 10, 2026 that states, "After reconsideration this date of service was still not paid in full for the 2026 fee schedule."

Amount In Dispute: $11.11

Respondent's Position

"The third EOB recommended a payment of $1,128, allowing for an additional recommendation of $11.11 more. It remains the Carrier's position that the Provider is not entitled to any additional monies."

Response Submitted By: Flahive, Ogden & Latson

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 Section 134.203 sets out the fee guidelines for professional medical services.

Adjustment Reasons

- P12 - Workers' compensation jurisdictional fee schedule adjustment.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. What is DWC considering in this medical fee dispute?
2. Did the respondent support additional payment made per fee guideline?
3. Has DWC determined whether the requester is entitled to additional reimbursement?

Findings

1. The requester is seeking $11.11 for date of service January 7, 2026, code 99213. Code 99080-73 has a zero amount in dispute.

2. The respondent submitted a response to MFDR that included an EOB with a post date of February 18, 2025 recommended the $11.11 be paid.

3. Based on the information available at the time of this review, the insurance carrier has supported that the billed amount was paid in full. No additional reimbursement is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence 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 additional 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	March 6, 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 electronico CompConnection@tdi.texas.gov.