



Medical Fee Dispute Resolution Findings and Decision General Information

Requester Name

Peak Integrated Healthcare

Respondent Name

Arch Indemnity Insurance Co.

MFDR Tracking Number

M4-25-2202-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

May 13, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
April 3, 2025	99213	\$144.37	\$144.37
April 3, 2025	99080-73	\$0.00	\$0.00
Total		\$144.37	\$144.37

Requester's Position

"AFTER RECONSIDERATION AND GIVING CORRECTIVE INFORMATION THEY ARE NOW STATING EOI AS REASON FOR DENIAL. THIS IS INCORRECT AS WE ARE AWARE OF NO DISPUTES..."

Amount in Dispute: \$144.37

Respondent's Position

Excerpt from position statement dated May 30, 2025: "...the dispute involves CPT code 99213 which is the office visit. The provider is seeking an additional \$144.37. The Carrier has reprocessed the provider's medical bill and is issuing payment to the provider in the amount of \$144.37. No interest is owed because the Carrier has not had the medical bill in its possession for 60 days. We would ask that once the provider receives payment, that the provider withdraw its request for Medical Fee Dispute Resolution on the basis that the dispute has resolved."

Response submitted by: Flahive, Ogden & Latson

Supplemental Position Statement dated August 21, 2025: "This one was returned after I had

processed for the additional payment stating it needed to be denied by the CE.”

“We received a peer review dated March 25, 2025, by Dr. [name] advising no further treatment is indicated per ODG and I was advised to dispute further medical bills for relatedness.”

Supplemental Response submitted by: Sedgwick Claims Management Services

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 resolving medical fee disputes.
2. [28 \(TAC\) §133.305](#) sets out general Medical Dispute Resolution guidelines.
3. [28 TAC §124.2](#) sets out Insurance Carrier Notification Requirements.
4. [28 TAC §134.203](#) sets out the fee guideline for professional medical services.

Denial Reasons

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

- 219 – BASED ON EXTENT OF INJURY.

Issues

1. What service will be reviewed in this Medical Fee Dispute Resolution process?
2. Is the disputed service eligible for review by Medical Fee Dispute Resolution (MFDR)?
3. Has the requester received reimbursement for the disputed service as of the date of this review?
4. Is the requester entitled to additional reimbursement for CPT code 99213?

Findings

1. A review of the DWC060 Medical Fee Dispute Resolution (MFDR) Request form submitted by the requester on May 13, 2025, finds that CPT code 99213 is in dispute for the amount of \$144.37 and that CPT code 99080-73 is in dispute for the amount of \$0.00. Therefore, DWC finds that only CPT code 99213 rendered on April 3, 2025, will be reviewed in this MFDR process.

2. A review of the submitted explanation of benefits (EOB) documents submitted finds that the service in dispute was denied payment by the insurance carrier in part due to "extent of injury."

28 TAC §133.305(b) states, "Dispute Sequence. If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability, or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021."

28 TAC §133.307(d)(2)(H) requires that if the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier shall attach a copy of any related Plain Language Notice in accordance with Rule §124.2 (relating to carrier reporting and notification requirements).

28 TAC §124.2(h) requires notification to the division and claimant of any dispute of disability or extent of injury using plain language notices (PLN) with language and content prescribed by the division. Such notices "... shall provide a full and complete statement describing the carrier's action and its reason(s) for such action. The statement must contain sufficient claim-specific substantive information to enable the employee/legal beneficiary to understand the carrier's position or action taken on the claim."

A review of the submitted documentation finds no copies, as required by Rule §133.307(d)(2)(H), of any PLN-11 or PLN 1 notices issued in accordance with Rule §124.2. The insurance carrier's denial reason is therefore not supported. DWC concludes that based on submitted documentation, there are no outstanding issues of compensability, extent, or liability for the injury.

DWC finds that the disputed service is eligible for review by MFDR.

3. A review of the submitted medical bill finds that on the disputed date of service the requester billed for CPT code 99213 in the amount of \$193.79.

A review of the submitted EOB dated April 16, 2025, finds that the insurance carrier erroneously represented the disputed CPT code as 99211 and allowed reimbursement for the erroneous CPT code in the amount of \$49.42.

A review of the submitted DWC060 MFDR Request form finds that the requester acknowledges it has received payment in the amount of \$49.42 for the disputed CPT code 99213 rendered on April 3, 2025.

DWC finds that as of the date of this review, the requester has received reimbursement in the amount of \$49.42 for the disputed CPT code 99213 rendered on April 3, 2025.

4. The requester is seeking additional reimbursement in the amount of \$144.37 for disputed CPT code 99213 rendered on April 3, 2025. Because the insurance carrier's denial reason is not supported, DWC finds that the requester is entitled to reimbursement.

CPT Code 99213 is defined as, "Office or other outpatient visits for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making (MDM). When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter."

DWC finds that 28 TAC §134.203 applies to the billing and reimbursement of disputed service CPT code 99213.

28 TAC §134.203(b)(1) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

28 TAC §134.203(c) states in pertinent part, "To determine the maximum allowable reimbursement (MAR) for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors and shall be effective January 1st of the new calendar year."

To determine the MAR the following formula is used:

$(\text{DWC Conversion Factor} / \text{Medicare Conversion Factor}) \times \text{Medicare Payment} = \text{MAR}$.

- The disputed date of service is April 3, 2025.
- The disputed service was rendered in zip code 75043, locality 11, Dallas; carrier 4412.
- The Medicare participating amount for CPT code 99213 in 2025 at this locality is \$89.32.
- The 2025 DWC Conversion Factor is 70.18.
- The 2025 Medicare Conversion Factor is 32.3465.
- Using the above formula, DWC finds the MAR is \$193.79 for CPT code 99213 on the disputed date of service.
- The respondent paid \$49.42.
- Reimbursement in the additional amount of \$144.37 is recommended for CPT code 99213 rendered on the disputed date of service.

DWC finds that the requester is entitled to additional reimbursement in the amount of \$144.37 for disputed CPT code 99213 rendered on April 3, 2025.

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 established that additional reimbursement in the amount of \$144.37 is due.

ORDER

Under Texas Labor Code §§413.031, the DWC has determined the requester is entitled to additional reimbursement for the disputed service. It is ordered that Arch Indemnity Insurance Co. must remit to Peak Integrated Healthcare, \$144.37 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		August 25, 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, please 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.texas.gov.