



Medical Fee Dispute Resolution Findings and Decision General Information

Requestor Name

Peak Integrated Healthcare

Respondent Name

Hartford Insurance Co. of Illinois

MFDR Tracking Number

M4-25-2376-01

Carrier's Austin Representative

Box Number 47

DWC Date Received

May 28, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
April 17, 2025	99080	\$119.50	\$119.50

Requestor's Position

"The above date of service was denied payment due to "services is not reimbursable for workers compensation injuries in this state. This is incorrect... And according to 28 Tex. Admin. Code § 134.120 - Reimbursement for Medical Documentation (f) The reimbursements for medical documentation are: (1) copies of medical documentation--\$.50 per page. Therefore, these charges for reimbursement for medical documentation should be paid in full."

Amount in Dispute: \$119.50

Respondent's Position

"After further review of the documentation submitted with this dispute, there is no additional amount warranted. The original bill for dos 4/17/25 was rec'd on 4/22/25 under control number ... and denied as the procedure is included/bundled within the value of another procedure performed."

Response submitted by: The Hartford

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. [Texas Labor Code \(TLC\) §408.0041 and TLC §408.025](#) addresses designated doctor examinations and the treating doctors' responsibilities regarding reports and medical records.
3. [28 TAC §127.10](#) sets out the rules for submitting documentation to designated doctors.
4. [28 TAC §134.120](#) sets out the fee guidelines for medical documentation.

Denial Reasons

The insurance carrier denied the payment for the disputed service with the following claim adjustment codes:

- 274 – SERVICE IS NOT REIMBURSABLE FOR WORKERS COMPENSATION INJURIES IN THIS STATE.
- 50 – THESE ARE NON-COVERED SERVICES BECAUSE THIS IS NOT DEEMED A MEDICAL NECESSITY BY THE PAYER.
- 97 & 243 – PAYMENT ADJUSTED BECAUSE THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
- W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAD BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- 2005 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION.

Issues

1. Is the insurance carrier liable for reimbursement to the treating doctor for providing copies of medical records to a designated doctor?
2. Are the insurance carrier's reasons for denial of payment supported?
3. Is the requestor entitled to reimbursement for the disputed service?

Findings

1. This dispute involves non-payment of charges billed by a treating doctor for the service of providing an injured employee's medical records to a designated doctor as ordered by DWC.

Texas Labor Code (TLC) §408.0041, states in pertinent part, "(c)The treating doctor and the insurance carrier are both responsible for sending to the designated doctor all of the injured employee's medical records relating to the issue to be evaluated by the designated doctor that are in their possession."

Per 28 TAC §127.10 (a)(1), "...The treating doctor and insurance carrier must provide the designated doctor copies of all the injured employee's medical records in their possession relating to the medical condition to be evaluated by the designated doctor.

"(A) For subsequent examinations with the same designated doctor, the treating doctor and insurance carrier must provide only those medical records not previously sent.

"(B) The cost of copying must be reimbursed in accordance with §134.120 of this title (relating to Reimbursement for Medical Documentation)."

28 TAC §134.120 states, in relevant part:

"(f) The reimbursements for medical documentation are:

- (1) copies of medical documentation--\$.50 per page;
- (2) copies of hospital records--an initial fee of \$5.00 plus \$.50 per page for the first 20 pages, then \$.30 per page for records over 20 pages;
- (3) microfilm--\$.50 per page;
- (4) copies of X-ray films--\$8.00 per film"

DWC finds that in accordance with Texas Labor Codes and Texas Administrative Code Rules referenced above, the insurance carrier is liable for reimbursement to the treating doctor for providing copies of medical records to a designated doctor.

2. A review of the explanation of benefits (EOB) documents submitted finds that the insurance carrier denied payment to the requestor for the service in dispute citing reason code 274, "Service is not reimbursable for workers' compensation injuries in this state."

As demonstrated in finding number one, DWC finds that in accordance with Texas Labor Codes and Texas Administrative Code Rules, the insurance carrier is liable for reimbursement to the treating doctor for providing copies of medical records to a designated doctor. Therefore, DWC finds that the insurance carrier's reason for denial of the disputed service is not supported.

3. The requestor is seeking reimbursement in the amount of \$119.00 for copies of medical record documents sent to a designated doctor, as ordered by DWC, billed under CPT code 99080, on April 17, 2025.

Because the insurance carrier’s denial of payment for the disputed service of providing copies of medical records to a designated doctor is not supported, DWC finds that the requestor is entitled to reimbursement in accordance with 28 TAC §134.120 (f), which sets the rate at \$0.50 per page.

A review of the submitted documentation finds a DWC Commissioner’s Order dated April 4, 2025, ordering that the treating doctor provide medical record copies to a designated doctor. The review of submitted documents further finds that the requestor provided 239 pages of medical records to the designated doctor as ordered by DWC.

DWC finds that, in accordance with 28 TAC §134.120 (f), the requestor is entitled to reimbursement of \$0.50 per page in the total amount of \$119.50 for the service in dispute.

The insurance carrier paid \$0.00 for the disputed service. Thus, DWC recommends reimbursement to the requestor in the amount of \$119.50 for the service of providing medical records to the designated doctor on April 17, 2025.

Conclusion

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

DWC finds the requestor has established that reimbursement is due in the amount of \$119.50.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the service in dispute. It is ordered that the Respondent, Hartford Insurance Co. of Illinois, must remit to the Requestor, Peak Integrated Healthcare, \$119.50 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		June 10, 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.