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
Peak Integrated Healthcare

Respondent Name
American Compensation Ins Co

MFDR Tracking Number
M4-25-2445-01

Carrier's Austin Representative
Box Number 60

DWC Date Received
June 4, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 20, 2025	99213	$193.79	$193.79
February 20, 2025	99080-73	$15.00	$15.00
	Total	$208.79	$208.79

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 May 13, 2025 and June 4, 2025 that states, "After reconsideration we were denied stating exact duplicate claim service. That is incorrect and we have not been given reason for denial or received payment for services."

Amount in Dispute: $208.79

Respondent's Position

The Austin carrier representative for American Compensation Ins Co is Downs Stanford PC. The representative was notified of this medical fee dispute on June 5, 2025.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available

information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

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 §134.203 sets out the reimbursement guidelines for professional medical services.

Denial Reasons

- 18/224 – Exact duplicate claim service.
- Duplicate to bill ID RTX-9190
- Lines 1,2 were duplicated against bill RTTX-9190 (Invoice: 509436723, DCN; 220250306COVRTW075464) which completed processing on 03-13-2025.

Issues

1. Did the insurance carrier make a payment for the disputed services?
2. What is the rule applicable to reimbursement?
3. Is the requester entitled to additional reimbursement?

Findings

1. The requester seeks payment of an office visit and work status report for date of service February 20, 2025. The only explanation of benefits included with the submitted documentation is dated May 23, 205 and indicates the claim is a duplicate of a claim that completed processing on March 13, 2025. Neither party submitted this EOB. The insurance carrier did not respond to this request for MFDR. Based on the information available at the time of this review, DWC finds insufficient evidence to support payment or appropriate denial of the disputed charges. The service in dispute will be reviewed per applicable fee guideline.
2. DWC Rule 28 Texas Administrative Code §134.203(c)(1) states, "…To determine to MAR for professional services, system participants shall apply the Medicare payment policies with minimal modification…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 $53.68…"

The following formula represents the calculation of the DWC MAR at §134.203 (c)(1) & (2).

(DWC Conversion Factor ÷ Medicare Conversion Factor) x Medicare Payment = MAR. In this instance, 70.18/32.3465 x $89.32 (CMS physician fee schedule allowable for location) = $193.79.

The requester is also seeking $15.00 for code 99808-73. DWC Rule 129.5 (e)(j) states, The doctor, delegated physician assistant, or delegated advanced practice registered nurse shall file the Work Status Report:

(1) after the initial examination of the injured employee, regardless of the injured employee's work status;
(2) when the injured employee experiences a change in work status or a substantial change in activity restrictions;…

(j) …The amount of reimbursement shall be $15. A doctor, delegated physician assistant, or delegated advanced practice registered nurse shall not bill in excess of $15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section.

Review of the submitted work status report indicates the injured worker had a change in work status (continued inability to return to work). The payment of the work status report is recommended.

3. The total allowable DWC fee guideline reimbursement is $208.79. This amount 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 Peak Integrated Healthcare has established that reimbursement of $208.79 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to reimbursement for the disputed services. It is ordered that American Compensation Insurance Co must remit to Peak Integrated Healthcare $208.79 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August 21, 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 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 electronico CompConnection@tdi.texas.gov.