TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name
Healthcare Express

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-25-2494-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
June 6, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 19, 2025	99203	$265.00	$168.96
March 19, 2025	S9088	$132.00	
March 19, 2025	73610	$88.00	
March 19, 2025	73630	$82.00	
March 19, 2025	L3260	$63.00	
March 19, 2025	99080-73	$32.00	
	Total	$662.00	$168.96

Requester's Position

The requester did not include a position summary with the medical fee dispute resolution request. Therefore, the division will render a decision based solely on the information available at the time of review.

Amount in Dispute: $662.00

Respondent's Position

"To resolve this fee reimbursement dispute, Texas Mutual has elected to reprocess the disputed services in accordance with the appropriate Medical Fee Guideline as defined per Texas Administrative Code Rule 134 - Guidelines for Medical Services, Charges and Payments."

Response Submitted by: Texas Mutual Insurance Company

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. TLC §413.011 sets out general reimbursement policies and treatment guidelines and protocols.
2. 28 Texas Administrative Code (TAC) §133.305 established procedures for resolving medical disputes.
3. 28 TAC §133.307 specifies the process for resolving medical fee disputes.
4. 28 TAC §134.203 provides the fee guidelines for professional medical services.
5. 28 TAC §129.5 sets out the fee guidelines for the DWC73 Work Status Reports.
6. 28 TAC §134.1 sets out medical reimbursement policies.
7. 28 TAC §141.1 provides the framework for dispute resolution and benefit review conferences.

Denial Reasons

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

- A19 – Rendering provider must bill for services. Update box 24J and box 31 of the CMS-1500 to reflect the rendering provider's information. Please correct CMS-1500 and submit a request for reconsideration.
- A19 – DWC rule 133.10, 133.20 & clean claim guide require license type, tax ID, NPI & state jurisdiction of licensed HCP who rendered services.
- A16 – The reimbursement for health care services is subject to WorkWell, TX contracts, a certified WC HCN (ins code Ch. 1305)
- G15 – Pricing is calculated based on the medical professional fee schedule value.
- H40 – No payment is made as Medicare uses another code for reporting and/or payment of this service
- CAC-P12 – Workers compensation jurisdictional fee schedule adjustment.

- CAC-P13 – Payment reduced or denied based on workers compensation jurisdictional regulations or payment policies.
- CAC-W3, 350 – In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- CAC-193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
- CAC-45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- DC4 – No additional reimbursement allowed after reconsideration.

Issues

1. Has the insurance carrier issued a payment following the submission of the Medical Fee Dispute Resolution (MFDR) request?
2. Did the insurance carrier maintain its original denial reasons after the MFDR request was submitted?
3. Is the requester entitled to reimbursement for the Work Status Report billed under CPT Code 99080-73?
4. Is the requester entitled to additional reimbursement for HCPCS Codes S9088 and L3260, and is the carrier's payment reduction supported?
5. Is the requester entitled to any additional reimbursement for the services rendered?

Findings

1. The requester seeks reimbursement totaling $662.00 for services provided on March 19, 2025, which include a Work Status Report, office visit, radiological examinations, a knee orthosis, and a miscellaneous service.

   In response to the MFDR request, the insurance carrier issued a partial payment of $302.71, along with $2.09 in interest, for a total of $304.80. The following table summarizes the carrier's payment:

Date of Service	CPT/HCPCS Codes	Amount Billed and Amount in Dispute	Amount Paid
March 19, 2025	99203	$265.00	$117.07
March 19, 2025	S9088	$132.00	$79.42
March 19, 2025	73610	$88.00	$43.75
March 19, 2025	73630	$82.00	$40.97
March 19, 2025	L3260	$63.00	$21.50
March 19, 2025	99080-73	$32.00	$15.00

The Division contacted the requester to confirm receipt of payment and to determine whether they wished to continue the MFDR process. No response was received. As a result, a decision has been made based on the information available at the time of review.

2. The requester submitted an MFDR request for services rendered on March 19, 2025, billed under CPT and HCPCS codes 99203, S9088, 73610, 73630, L3260, and 99080-73. Following the MFDR submission, the carrier issued payment for the disputed services.

   Given that payment was subsequently made, the original denial reasons are no longer applicable. Accordingly, the Division will determine whether the reimbursement complies with the applicable guidelines under 28 Texas Administrative Code (TAC) §134.203, which adopts Medicare-based methodologies for coding, billing, and reporting, and reimbursement in the Texas Workers' Compensation system.

3. The requester seeks reimbursement for CPT Code 99080-73. Pursuant to 28 TAC §129.5(i)(1), reimbursement for Work Status Reports is $15.00. The rule specifies:

   "A doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report... The amount of reimbursement shall be $15. A doctor shall not bill in excess of $15…"

   A review of the submitted documentation finds that the requester has established that reimbursement is due. As a result, a payment in the amount of $15.00 is recommended.

4. The requester billed $132.00 for HCPCS Code S9088 and $63.00 for HCPCS Code L3260. The carrier paid $79.42 and $21.50, respectively, and reduced the remainder using denial/reduction codes: P12, 45, W3, 920, DC3, DC5, and 350.

   There is no established fee guideline for these codes. Reimbursement is therefore governed by the fair and reasonable standards under:

   - 28 TAC §134.1(e)(3) and §134.1(f)
   - Texas Labor Code §413.011(d)

   These provisions require reimbursement that:

   - Reflects fair and reasonable market value
   - Promote quality medical care
   - Ensures effective cost control
   - Does not exceed payment for comparable treatment provided to individuals with similar socioeconomic status

Upon review, the documentation submitted does not justify the requested reimbursement. Specifically:

- No evidence was provided to demonstrate that the billed amounts reflect fair and reasonable market value.

- No evidence supports that the charges promote cost control or align with pricing for similar socioeconomic groups.
- The billed charges appear to reflect the provider's usual and customary rates, which alone do not meet fair and reasonable standards.

The DWC finds that the requester has not demonstrated entitlement to additional reimbursement for these codes.

5. The Division finds that the requester is entitled to additional reimbursement for the following services:

   - Office Visit (CPT Code 99203)
   - Radiological Exams (CPT Codes 73610 and 73630)

   Reimbursement is calculated under 28 TAC §134.203(c)(1) using the formula:

   (DWC Conversion Factor ÷ Medicare Conversion Factor) × Medicare Payment = Maximum Allowable Reimbursement (MAR)

   - Date of Service: March 19, 2025
   - Place of Service ZIP Code: 75604
   - Medicare Locality: Rest of Texas

   Participating Provider Rate: CPT code 99203 = $105.80
   - MAR: $229.55
   - Amount Billed: $265.00
   - Amount Paid: $117.07
   - Recommended Amount: $112.48

   Participating Provider Rate: CPT code 73610 = $33.61
   - MAR: $72.92
   - Amount Billed: $88.00
   - Amount Paid: $43.75
   - Amount Recommended: $29.17

   Participating Provider Rate: CPT code 73630 = $31.47
   - MAR: $68.28
   - Amount Billed: $82.00
   - Amount Paid: $40.97
   - Amount Recommended: $27.31

The DWC finds that the requester has established that additional reimbursement in the amount of $183.96, the insurance carrier issued a payment in the amount of $15.00, as a result, additional reimbursement is recommended in the amount of $168.96.

Conclusion

The resolution of this medical fee dispute is determined by the evidence provided by both the requester and the respondent during the adjudication process. While not all evidence may have been thoroughly discussed, all relevant information was considered in reaching a decision.

The DWC finds the requester has established that reimbursement 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 the respondent must remit to the requester $168.96 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		October 23, 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 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 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 512-804-4812.