



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Peak Integrated Healthcare

Respondent Name

Hartford Fire Insurance Company

MFDR Tracking Number

M4-25-3017-01

Carrier's Austin Representative

Box Number 47

DWC Date Received

July 22, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 18, 2025	99080-73	\$0.00	\$0.00
June 18, 2025	99213	\$7.90	\$7.90
Total		\$7.90	\$7.90

Requester's Position

"FULL payment for the CPT code 99213, according to the 2025 fee schedule is \$193.79."

Amount in Dispute: \$7.90

Respondent's Position

"The original bill for dos 6/18/25 was received on 6/19/25 under control number ... and paid \$200.80. Bill paid at charged amount Bill processed on 6/19/25."

Response Submitted by: The Hartford

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. 28 Texas Administrative Code ([TAC](#)) [§133.305](#) sets out the procedures for resolving medical disputes.
2. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.
3. [28 TAC §134.203](#) sets out the fee guideline for professional medical services.

Denial Reasons

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

- W3 – Bill is a reconsideration or appeal.
- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
- 1115 - We find the original review to be accurate and are unable to recommend any additional allowance.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. Is the insurance carrier's denial supported?
2. Is the requester entitled to reimbursement?

Findings

1. This dispute pertains to a reduction of payment for an evaluation and management service rendered on June 18, 2025, and billed under CPT code 99213. The insurance carrier issued a payment in the amount of \$185.89, and the requester is seeking additional reimbursement in the amount of \$7.90. The carrier denied additional reimbursement under denial code 193, indicating that the original payment determination is being maintained. A review of the submitted documentation demonstrates that the services were billed appropriately therefore will be reviewed pursuant to the applicable rules and guidelines.

The fee guidelines for disputed services are found at 28 TAC §134.203.

28 TAC §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid

Services (CMS) payment policies specific to Medicare.”

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.”

The requester billed CPT code 99213 defined as “Established patient office or other outpatient visit, 20-29 minutes.”

2. 28 TAC §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...”

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = Maximum Allowable Reimbursement (MAR).

- The 2025 DWC Conversion Factor is 70.18
- The 2025 Medicare Conversion Factor is 32.3465
- A review of the medical bills finds that the disputed services were rendered in zip code 75043; the locality is “Dallas.”
- The Medicare Participating amount for CPT code 99213 at this locality is \$89.32.
- Using the above formula, the DWC finds the MAR is \$193.79.
- The respondent paid \$185.89.
- Additional reimbursement of \$7.90 is recommended for date of service June 18, 2025.

The DWC finds that the requester is entitled to additional reimbursement for the disputed services. As a result, \$7.90 is due

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.

The DWC finds the requester has established that additional reimbursement of \$7.90 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 \$7.90 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

September 8, 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, 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.