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

Ace American Insurance Company

MFDR Tracking Number

M4-25-3140-01

Insurance Carrier's Austin Representative

BOX 15 Downs Stanford PC

DWC Date Received

July 30, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
May 20, 2025	99080 Medical Documentation	161.50	$0.00
	Total	$161.50	$0.00

Requester's Position

"AFTER RECONSIDERATION WE WERE AGAIN DENIED GIVING ONLY A $0.50 PAYMENT.' WE HAVE ATTACHED DOCUMENTATION AND SUFFICIENT RULES SUPPORTING PAYMENT FOR SERVICES/DOCUMENTATION SUBMITTED PER TDI RULES."

Amount In Dispute: $161.50

Respondent's Position

"The Requestor's bill for DOS 05/20/2025 in the amount of $162 was received by the Carrier on 05/20/2025 – via fax Unfortunately, the bill was denied incorrectly as not separately payable (CARC 234) …

"The Respondent paid the provider in accordance with billing. Box 24G is the Units column. The Requestor entered '1' in this column. Payment for copying records is based on the number of pages. Nowhere on the Requestor's billing do they identify the number of pages copied."

Response Submitted By: CorVel

Findings and Decision

Authority

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

Statutes and Rules

1. 28 Texas Administrative Code (TAC) Section 133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC Section 127.10 provides the general procedures for designated doctor examinations.
3. 28 TAC Section 133.10 sets out the requirements for a complete medical bill.
4. 28 TAC Section 134.120 sets out the fee guidelines for medical documentation.

Adjustment Reasons

The insurance carrier reduced payment for the disputed services with the following reasons:

1. 234 – This procedure is not paid separately.
2. P12 – Workers' Compensation State Fee Schedule Adj

Issues

1. What is DWC considering in this medical fee dispute?
2. Is the requester entitled to additional reimbursement?

Findings

1. The requester is seeking reimbursement of $161.50 for sending medical documentation to a designated doctor billed with procedure code 99080 for one unit on date of service May 20, 2025. DWC will review this service for reimbursement.

2. DWC finds that 28 TAC Section 133.10(f)(1)(T) requires the number of units for the billed service in CMS-1500, field 24G. The requester billed one unit in this field.

   28 TAC Section 134.120(f)(1) states that the reimbursement for copies of medical documentation is $.50 per page. In a document dated May 20, 2025, submitted as evidence, the requester indicated that it submitted "324 pages of medical records." However, since the requester only indicated a single unit on the medical bill, the maximum allowable reimbursement (MAR) would be $0.50. Per explanation of benefits dated July 10, 2025, the insurance carrier paid for one unit ($0.50) as billed. No additional reimbursement is recommended.

Conclusion

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

DWC finds the requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code Sections 413.031 and 413.019, DWC has determined the requester is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		February 2, 2026
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 Section 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 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 this *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC Section 141.1(d).

Si prefiere hablar con una persona en español acerca de esta correspondencia, favor de llamar a 800-252-7031, opción tres o correo electronico CompConnection@tdi.texas.gov.