



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Peak Integrated
Healthcare

Respondent Name

ALG Property Casualty Co

MFDR Tracking Number

M4-25-3397-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

August 26, 2025

Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|------------------|-------------------|-------------------|-----------------|
| June 10, 2025 | 99213 | \$193.79 | \$193.79 |
| June 10, 2025 | 99080-73 | \$15.00 | \$15.00 |
| Total | | \$208.79 | \$208.79 |

Requester's Position

"After reconsideration we denied payment again stating 'duplicate and workers comp fee adjustment.' This is incorrect and all other dates of service for this compensable injury have been paid."

Amount in Dispute: \$208.79

Respondent's Position

The Austin carrier representative for ALG Property Casualty Co is Flahive, Ogden & Latson. Flahive, Ogden & Latson was notified of this medical fee dispute on August 27, 2025. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information. As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

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.

Denial Reasons

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

- 00663 – Reimbursement has been calculated based on the state guidelines.
- 18-1 – Duplicate claim/service.
- TX224 – Duplicate charge.
- 93 – No claim level adjustments.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issue

1. Is the requester entitled to reimbursement?

Findings

1. The requester seeks reimbursement for CPT code 99213 and CPT code 99080-73 rendered on June 10, 2025. The insurance carrier denied the services in dispute citing fee schedule adjustments and reimbursement has been calculated based on the state guidelines.

A review of the submitted document finds that the insurance carrier's denial reasons are not support. The requester is therefore entitled to reimbursement.

28 TAC §134.203 and 28 TAC §129.5 applies to the reimbursement of the disputed service.

28 TAC §129.5(i)(1) states ".... The amount of reimbursement shall be \$15. A doctor 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... Doctors billing for Work Status Reports as permitted by this section shall do so as follows: (1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section."

The DWC 73 rendered on June 10, 2025, met the documentation requirements outlined in 28 TAC §129.5. The requester is therefore entitled to reimbursement in the amount of \$15.00.

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 CPT code description for 99213 is, “A medical evaluation and management (E/M) service provided by physicians. This code is used to document and bill for a level three office visit, which involves a face-to-face encounter with the patient for the evaluation and treatment of a new or existing problem.”

A review of the medical documentation finds that the requester supported the level of service billed.

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 service date is June 10, 2025.
- 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 11, “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 requester seeks \$193.79.
- The respondent paid \$0.00.
- Reimbursement of \$193.79 for CPT code 99213 and \$15 for 99080-73 is recommended for a total amount of \$208.79.

The DWC finds that the requester is entitled to reimbursement for the disputed service. As a result, \$208.79, 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 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 the respondent must remit to the requester \$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

November 20, 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 along with a **copy** of the **Medical Fee Dispute 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