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

General Information

Requester Name
Peak Integrated HealthCare

Respondent Name
Mitsui Sumitomo Insurance Co

MFDR Tracking Number
M4-25-3410-01

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
August 12, 2024	99080-73	$15.00	Dismissed
August 12, 2024	99213	$185.89	Dismissed
October 7, 2024	99080-73	$15.00	Dismissed
October 7, 2024	99213	$185.89	Dismissed
February 17, 2025	99080-73	$15.00	$0.00
February 17, 2025	99213	$193.79	$193.79
	Total	$610.57	$193.79

Requester's Position

The requester did not submit a position statement with this request for MFDR. They did submit a copy of a reconsideration dated July 25, 2025 and August 26, 2025 that states, "After reconsideration we were again denied stating 'unnecessary medical treatment based on peer review.' We disagree; we are only treating what are compensable injuries. This is incorrect. We are authorized to treat..."

Amount in Dispute: $610.57

Respondent's Position

The Austin carrier representative for Mitsui Sumitomo Insurance Co is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on August 29, 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 §133.240 sets out guidelines for medical payment and denials.
3. 28 TAC §134.203 sets out the reimbursement guidelines for professional medical services.
4. 28 TAC §19.2001 sets out the requirements of utilization review for health care provided under workers' compensation insurance coverage.
5. 28 TAC §129.5 sets out the reimbursement guidelines for work status reports.

Denial Reasons

- 219 Based on extent of injury
- 2 – Charge unrelated to the compensable injury.
- 216 – Based on the findings of a review organization.
- 2 – Unnecessary treatment with peer review.
- 18 – Duplicate claim/service.
- P&S/ MMI with no future medical care.

Issues

1. Did the carrier follow the appropriate administrative process to address the denial based on IRO review?
2. Did the carrier raise extent of injury?

3. What is the rule applicable to reimbursement?
4. Did the requester support payment due for work status report?
5. Is the requester entitled to additional reimbursement?

Findings

1. The requester is seeking reimbursement of professional medical services from August 12, 2024 through February 17, 2025. The insurance carrier denied based on findings of a review organization. DWC Rule 28 Texas Administrative Code §133.240 (q) states, in relevant part, "When denying payment due to an adverse determination under this section, the insurance carrier shall comply with the requirements of §19.2009 of this title ...

   Additionally, in any instance where the insurance carrier is questioning the medical necessity or appropriateness of the health care services, the insurance carrier shall comply with the requirements of §19.2010 of this title …, including the requirement that prior to issuance of an adverse determination the insurance carrier shall afford the health care provider a reasonable opportunity to discuss the billed health care with a doctor ..."

   Submitted documentation does not support that the insurance carrier followed the appropriate procedures for a retrospective review denial of the disputed services outlined in §19.2003 (b)(31) or §133.240 (q).

   Therefore, the insurance carrier did not appropriately raise medical necessity for this dispute, and this denial reason will not be considered in this review.
2. The documentation submitted with this request contained a PLN11 compensability. The explanation of benefits submitted with this dispute indicates dates of service August 12, 2024 and October 7, 2024 were denied based on extent of injury and charges unrelated to the compensable injury. The documentation provided confirms that the insurance carrier denied reimbursement due to unresolved questions regarding the extent of injury [compensability], [liability], [relatedness] for the same services involved in the medical fee dispute. The carrier issued the Explanation of Benefits (EOB) timely and in compliance with 28 TAC §133.240.

   Pursuant to 28 TAC §133.305(b), when a dispute concerning compensability, liability, or relatedness exists for the same services subject to a fee dispute, that issue must be resolved before the medical fee dispute can be adjudicated, in accordance with Labor Code §§413.031 and 408.021.

   The Division concludes that the disputed services involve an unresolved extent of injury, compensability, issue; therefore, this request is ineligible for medical fee adjudication under 28 TAC §133.307.

   The Division notifies the requester that the appropriate process to resolve disputes regarding extent of injury compensability is governed by Texas Labor Code Chapter 410 and 28 TAC §141.1. The requester may file DWC Form-045, Request to Schedule, Reschedule, or Cancel a Benefit Review Conference (BRC), to address this matter.

Accordingly, the Division finds the disputed charges are dismissed due to unresolved extent of injury [compensability], [liability], [relatedness] issues.

3. 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…

   (1) 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 $52.83...
   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year…"

   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,

   - The 2024 WC Conversion Factor is $70.18
   - The 2024 Medicare Conversion Factor is $32.3465
   - The CMS allowable for location code 0041211 (Garland zip code 75043) is $89.32
   - 67.81/33.2875 x $89.32 = $185.89
   - The 2025 WC Conversion Factor is $70.18
   - The 2024 Medicare Conversion Factor is $32.3465
   - The CMS allowable for location code 0041211 (Garland zip code 75043) is $89.32
   - 67.81/33.2875 x $89.32 = $193.79

4. The requester is also seeking $15.00 for code 99808-73. DWC Rule 28 TAC §129.5 (e)(g) 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; and
   (1) on the schedule requested by the insurance carrier, its agent, or the employer requesting the report through its insurance carrier, which shall not exceed one report every two weeks and which shall be based upon the doctor's, delegated physician assistants, or delegated advanced practice registered nurse's scheduled appointments with the injured employee.

   (g) In addition to the requirements under subsection (e) of this section, the treating doctor, delegated physician assistant, or delegated advanced practice registered nurse shall file the Work Status Report with the insurance carrier, employer, and injured employee within seven

days of the day of receipt of:

(1) functional job descriptions from the employer listing available modified duty positions that the employer is able to offer the injured employee as provided by §129.6(a) of this title (relating to Bona Fide Offers of Employment); or

(2) a required medical examination doctor's Work Status Report that indicates that the injured employee can return to work with or without restrictions.

Review of the submitted DWC073 for dates of service August 12, 2024, October 7, 2024, and February 17, 2025 found no change in work status or activity restrictions. No payment is recommended.

5. The total allowable DWC fee guideline reimbursement is $193.79. 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 requester has established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to additional reimbursement for the disputed services. It is ordered that Mitsui Sumitomo Insurance Co must remit to Peak Integrated Healthcare $193.79 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 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.