



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Clinics of North Texas LLP

Respondent Name

Everest National Insurance Co

MFDR Tracking Number

M4-26-0630-01

Insurance Carrier's Austin Representative

BOX 19 Flahive Ogden & Latson

DWC Date Received

November 4, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
March 4, 2025	99213-25	\$215.00	\$0.00
March 4, 2025	99080-73	\$25.00	\$0.00
Total		\$240.00	\$0.00

Requester's Position

"The original bill was submitted, and you have denied as '01-Service not authorized as required.'"

Amount In Dispute: \$240.00

Respondent's Position

"The bill(s) in question was/were escalated and a review completed. Our bill audit company has determined that additional monies are owed in the amount of \$202.33. Interest in the amount of \$8.45 has been added. Attached are an updated copy of the Explanation of Benefits and payment summaries for your records. We are requesting the dispute be withdrawn."

Response Submitted By: Gallagher Bassett

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 [134.203](#) sets out the fee guidelines for professional medical services.
3. 28 TAC Section [129.5](#) sets out the requirements for work status reports.

Adjustment Reasons

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

1. 000050 – Services not authorized as required.
2. 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer.
3. 193, 90563 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
4. 56 – Claim/service denied because procedure/treatment has not been deemed 'proven to be effective' by the payer.
5. P12 – Workers' compensation jurisdictional fee schedule adjustment.
6. Reimbursement has been calculated based on the state guidelines.
7. 309 – The charge for this procedure exceeds the fee schedule allowance.
8. 5283 – Additional allowance is not recommended as this bill was reviewed in accordance with state guidelines, usual and customary policies, provider's contract or carrier decision.
9. 93 – No claim level adjustment.

Issues

1. What is DWC considering in this medical fee dispute?
2. Has the insurance carrier issued payment for the disputed fee amount as the date of this review?
3. Is the requester entitled to additional reimbursement for CPT Code 99213?
4. Is the requester entitled to additional reimbursement for CPT Code 99080-73?

Findings

1. The requester is seeking reimbursement in the amount of \$240.00 for CPT Code 99213-25 and 99080-73 rendered on March 4, 2025. The insurance carrier denied payment with denial codes 000050 and 50 (descriptions indicated above). The insurance carrier issued payment

after the MFDR submission.

2. A review of the documentation provided by the insurance carrier reflects payment details related to the disputed date of service, March 4, 2025. Upon review, the insurance carrier issued payment in the amount of \$202.33, plus interest of \$8.45, for a total payment of \$210.78.

DWC finds that because the insurance carrier issued payment after the MFDR submission, the denial reasons were not upheld. The determination of whether the insurance carrier issued payment in accordance with the applicable medical fee guidelines is addressed in this dispute.

3. 28 TAC Section 134.203 applies to the reimbursement for CPT Code 99213.

28 TAC Section 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 March 4, 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 76302; the locality is 99, Rest of Texas.

- The Medicare Participating amount for CPT code 99213 at this locality is \$86.34
- Using the above formula, the DWC finds the MAR is \$187.33
- The requester seeks \$215.00
- The respondent paid \$187.33

The DWC finds that the requester is not entitled to additional reimbursement for CPT Code 99213.

4. CPT code 99080-73 is defined as "Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form

TAC Section 129.5(d) states, "The doctor, delegated physician assistant, or delegated advanced practice registered nurse shall be considered to have filed a complete Work Status Report if the report is filed in the form and manner prescribed by the division, signed, and contains at minimum:

(1) identification of the injured employee's work status;

(2) effective dates and estimated expiration dates of current work status and restrictions (an expected expiration date is not binding and may be adjusted in future Work Status Reports, as appropriate, based on the condition and progress of the injured employee);

(3) identification of any applicable activity restrictions;

(4) an explanation of how the injured employee's workers' compensation injury prevents the injured employee from returning to work (if the doctor believes that the injured employee is prevented from returning to work); and

(5) general information that identifies key information about the claim (as prescribed on the report)."

28 TAC Section 129.5(j) states, "Notwithstanding any other provision of this title, a doctor, delegated physician assistant, or delegated advanced practice registered nurse may bill for, and an insurance carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the insurance carrier, its agent, or the employer through its insurance carrier asks for an extra copy. The amount of reimbursement shall be \$15. A doctor, delegated physician assistant, or delegated advanced practice registered nurse 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, delegated physician assistants, or delegated advanced practice registered nurses are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors, delegated physician assistants, or delegated advanced practice registered nurses 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, delegated physician assistant, or delegated advanced practice registered nurse is billing for a report required under subsections (e)(1), (e)(2), and (g) of this section; ..."

A review of the documentation finds the requester completed the work status report in accordance with the applicable rules. The insurance carrier issued a payment of \$15.00, therefore DWC finds that the requester is not entitled to additional reimbursement.

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 17, 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 electrónico CompConnection@tdi.texas.gov.