Division of Workers' Compensation

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Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Peak Integrated Healthcare

Respondent Name

National Fire Ins Co of Hartford

MFDR Tracking Number

M4-26-0753-01

Insurance Carrier's Austin Representative

BOX 57 Continental Casualty Co

DWC Date Received

November 18, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
August 20, 2025	99080 Medical Documentation	$143.50	$0.00
	Total	$143.50	$0.00

Requester's Position

"AFTER RECONSIDERATION WE WERE AGAIN DENIED STATING 'NON COVERED CHARGE.' WE DISAGREE. WE HAVE ATTACHED DOCUMENTATION AND SUFFICIENT RULES SUPPORTING PAYMENT FOR SERVICES/DOCUMENTATION SUBMITTED PER TDI RULES."

Amount In Dispute: $143.50

Respondent's Position

"Carrier maintains any and all denials as represented in the provided EORs."

Response Submitted By: Law Office of Brian J. Judis

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 denied payment for the disputed services with the following reasons:

1. 4 – The procedure code is inconsistent with the modifier used.
2. 10 – The billed service requires the use of a modifier code
3. 96 – Non-covered charge(s).
4. 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
5. 242 – According to the fee schedule, this charge is not covered.
6. 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
7. 2005 – No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. What is DWC considering in this medical fee dispute?
2. Is the service in question a covered charge?
3. Is the insurance carrier's denial based on lack of a modifier supported?
4. Is the requester entitled to reimbursement?

Findings

1. The requester is seeking reimbursement of $143.50 for sending medical documentation to a designated doctor billed with procedure code 99080 for one unit on date of service August 20, 2025. The insurance carrier denied payment in full. DWC will review this service for reimbursement.

2. An explanation of benefits dated November 9, 2025, denied payment stating, "According to

the fee schedule, this charge is not covered."

28 TAC Section 127.10(a)(1) states, in relevant part, "The treating doctor and insurance carrier must provide the designated doctor copies of all the injured employee's medical records in their possession relating to the medical condition to be evaluated by the designated doctor … (B) The cost of copying must be reimbursed in accordance with §134.120 of this title …"

DWC finds that submission of medical documents to a designated doctor is a covered service. The insurance carrier's denial of payment for this reason is not supported.

3. The insurance carrier also denied payment based on the lack of a modifier. DWC finds that no modifier applies to the service in question.

4. 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 August 20, 2025, submitted as evidence, the requester indicated that it submitted "287 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.

   Based on the evidence presented, the requester is seeking $143.50. DWC finds that the service as billed does not support entitlement to this amount. DWC finds that the requester is not entitled to reimbursement for the service in question.

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 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

Signature	Medical Fee Dispute Resolution Officer	February 2, 2026 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.