TDI 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
Standard Fire Insurance

MFDR Tracking Number
M4-26-1148-01

Insurance Carrier's Austin Representative
BOX 5 Travelers Co Inc

DWC Date Received
December 11, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
August 14, 2025	99080 Medical Documentation	$221.00	$0.00
	Total	$221.00	$0.00

Requester's Position

"The above date of service was denied payment. THIS BILL SHOULD BE PAID IN FULL AND ALL DOCUMENTATION NECESSARY IS ATTACHED."

Amount In Dispute: $221.00

Respondent's Position

"The EOB denied the services as not reimbursable. They are not included within the Medical Fee Guidelines ... The provider is not entitled to any reimbursement."

Response Submitted By: Flahive, Ogden & Latson

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. 96 – Non-covered charge(s).
2. 242 – According to the fee schedule, this charge is not covered.
3. 18 – Exact duplicate claim/service
4. 247 – A payment or denial has already been recommended for this service.

Issues

1. What is DWC considering in this medical fee dispute?
2. Is the insurance carrier's denial of payment supported?
3. Is the requester entitled to reimbursement?

Findings

1. The requester is seeking reimbursement of $221.00 for sending medical documentation to a designated doctor billed with procedure code 99080 for one unit on date of service August 14, 2025. The insurance carrier denied payment in full. DWC will review this service for reimbursement.

2. Per explanation of benefits dated October 15, 2025, the insurance carrier 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. 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 14, 2025, submitted as evidence, the requester indicated that it submitted 442 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 $221.00. 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.