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

Ortholonestar

Respondent Name

City of Dallas

MFDR Tracking Number

M4-26-1586-01

Insurance Carrier's Austin Representative

BOX 53 Hoffman Kelley LLP

DWC Date Received

February 2, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
October 6, 2023	99213 and 99080	$189.71	$0.00
	Total	$189.71	$0.00

Requester's Position

"The claim was received by IMO on November 30, 2023, and it was audited on January 18, 2024. IMO recommended $189.71 for CPT 99213 ($174.71) and CPT 99080 ($15.00). We did not received the EOB, so we requested one from IMO on July 24, 2024. On July 30, 2024, we learned of a recommendation."

Amount In Dispute: $$187.71

Respondent's Position

"We are in receipt of the Medical Fee Dispute Resolution concerning injured employee [injured employee name] from Orth Lone Star for dates of service 10/06/2023. Based on the submitted documentation and review of guidelines, no additional payment is recommended. A copy of the previously paid EOB and payment details have been included for your reference."

Response Submitted By: Injury Management Organization Inc

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 133.305 sets out the procedures for resolving medical disputes.

Adjustment Reasons

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

- P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. What is DWC considering in this medical fee dispute?
2. Was this request for medical fee dispute resolution submitted timely?

Findings

1. The requester is seeking reimbursement for an office visit and a work status report, billed under CPT codes 99213 and 99080-73, totaling $248.00. The requester submitted a claim to the insurance carrier and the carrier paid $189.71 and applied reduction reason code P12 – Workers' Compensation Jurisdictional Fee Schedule Adjustment.

2. According to 28 Texas Administrative Code (TAC) Section 133.307(c)(1), a request for Medical Fee Dispute Resolution (MFDR) must be submitted no later than one year after the date of the disputed service, except in certain limited circumstances outlined in subsection (B) of the same provision.

   Specifically, 28 TAC Section 133.307(c)(1)(B) allows for a later filing if one of the following conditions applies:

   (i) A related dispute concerning compensability, extent of injury, or liability under Labor Code Chapter 410 has been filed. In such cases, the medical fee dispute must be submitted within 60 days after the requester receives the final decision on compensability, extent of injury, or liability, including all appeals.
   (ii) A dispute regarding medical necessity has been filed. Here, the medical fee dispute must be filed within 60 days after the requester receives the final decision on medical necessity, including all appeals, for the specific health care services in question that were previously denied by the insurance carrier based on medical necessity.

(iii) The dispute arises from a refund notice issued following a division audit or review. In this situation, the medical fee dispute must be filed within 60 days after the requester receives the refund notice

In this case, codes 99213 and 99080 were provided on October 6, 2023. The Division received the MFDR request on February 2, 2026, which is more than one year after the date(s) of service. Upon review of the documentation provided, there is no indication that the dispute falls within any of the exceptions described in 28 TAC Section 133.307(c)(1)(B).

The Division finds the requester has not established that reimbursement is due.

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

[redacted]	[redacted]	February 20, 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 electronico CompConnection@tdi.texas.gov.