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

General Information

Requester Name

Functional Recovery Associates LLC

Respondent Name

Zurich American Insurance Company

MFDR Tracking Number

M4-26-1834-01

Insurance Carrier's Austin Representative

BOX 19 Flahive Ogden & Latson

DWC Date Received

February 25, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
February 3, 2026	99215	$362.20	$0.00
	Total	$362.20	$0.00

Requester's Position

"It is our position that the charges are reasonable and well within the usual and customary charge for this type of procedure. Therefore, we request immediate reconsideration of the reduction of charges."

Amount In Dispute: $362.20

Respondent's Position

"Our initial response to the above referenced medical fee dispute resolution is as follows: we have escalated the bills in question for manual review to determine if additional monies are owed."

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.

Adjustment Reasons

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

- 00663 – Reimbursement has been calculated based on the state guidelines.
- 181 – Procedure code was invalid on the date of service.
- M51 – Missing/incomplete/invalid procedure code(s).
- XXF01 – This code is not found in the state's fee schedule.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. What is DWC considering in this medical fee dispute?

2. Is the denial of invalid code supported?

3. Does the submitted documentation support a high level of decision making?

Findings

1. The requester, Functional Recovery Associates PLLC seeks reimbursement in the amount of $362.20 for code 99215 for date of service February 3, 2026.

2. The insurance carrier denied the code at the time of adjudication stating the code was invalid on the date of service.

   28 TAC 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;

28 TAC 134.203(a)(5) states, "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing…

A review of the applicable AMA guidelines and the CMS Physician Fee Schedule confirms that CPT code 99215- Office or other outpatient visit for the evaluation and management of an established patient requiring a medically appropriate history and/or examination and a high level of medical decision-making, is a valid code with an assigned reimbursement value under the CMS Physician Fee Schedule for 2026 dates of service. Therefore, the insurance carrier's denial is not supported. The disputed code will be reviewed in accordance with the applicable fee schedule guidelines.

3. As noted above, CPT code 99215 requires a high level of medical decision-making. The requirements set forth under the American Medical Association (AMA) guidelines are listed below:
   - Number and Complexity of Problems addressed at the Encounter
     - One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment.
   - Amount and/or Complexity of Data to be Reviewed and Analyzed.
     - Extensive – must meet the requirements of at least 2 out of 3 categories
     - Tests, documents or independent historians or
     - Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported) or Discussion of management or
     - Test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported).
   - Risk of Complications and/or Morbidity or Mortality of Patient Management
     - High risk of morbidity from additional diagnostic testing or treatment.

   A review of the submitted physician evaluation from Functional Recovery Associates, PLLC, dated February 3, 2026, does not support the requirements for a high level of medical decision-making as outlined above. Therefore, reimbursement for CPT code 99215 is not recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence the 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	May 8, 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.