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

General Information

Requester Name
Peak Integrated Healthcare

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-26-1960-01

Insurance Carrier's Austin Representative
BOX 54 Texas Mutual Insurance Co

DWC Date Received
March 11, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
October 14, 2025	99213	$193.79	$0.00
October 14, 2025	99080-73	$15.00	$0.00
	Total	$208.79	$0.00

Requester's Position

"Our office respectfully requests Medical Fee Dispute Resolution regarding the carrier's denial of CPT 99213 for the above reference claim. The carrier denied the office visit stating that the service is included in another procedure performed on the same date. However, the documentation supports that a separate and medically necessary evaluation and management service was performed related to the compensable injury. A reconsideration request was submitted to the carrier, and the denial was maintained. Therefore, we are requesting review by the Division and payment according to the Texas Workers' Compensation Medical Fee Guidelines."

Amount In Dispute: $208.79

Respondent's Position

"On 10/17/2025, Texas Mutual received the attached bill for reimbursement. Peak Integrated Healthcare was billing for the preauthorized work hardening program as well as an office visit and TWCC-73, work status report. The program was reimbursed per fee schedule, and the office visit was denied as global/inclusive to the program as appropriate. Additionally, the TWCC-73 was denied as there were no changes to the work status or restrictions from the previous work status report submitted. (Attached) Our position is that no additional payment is due."

Response Submitted By: Texas Mutual Insurance Company

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. CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
2. CAC-97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
3. G15 – Pricing is calculated based on the medical professional fee schedule value.
4. 217 – The value of this procedure is included in the value of another procedure performed on this date.
5. 248 – DWC-73 in excess of the filing requirements: no change in work status and/or restrictions. Reimbursement denied per rule 129.5.
6. CAC-193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
7. 350 – In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
8. 891 – No additional payment after reconsideration.
9. CAC-W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. What is DWC considering in this medical fee dispute?
2. Is the insurance carrier's reimbursement denial reason of CPT code 99213 supported?
3. Is the insurance carrier's reimbursement denial reason of CPT code 99080-73 supported?
4. Is the requester entitled to reimbursement?

Findings

1. This medical fee dispute resolution (MFDR) request involves non-payment for an evaluation and management office visit billed under CPT code 99213 and non-payment of a Work status Report billed under CPT code 99080-73.

   DWC notes that on the disputed date of service, October 14, 2025, the requester also billed for CPT codes 97545-WH and 97546-WH which represent work hardening program services. The work hardening services have been reimbursed and are not in dispute.

   The requester seeks reimbursement for CPT codes 99213 and 99080-73 rendered on October 14, 2025. DWC will review the submitted documentation to determine if the requester is entitled to reimbursement for CPT codes 99213 and 99080-73 billed on October 14, 2025, in accordance with DWC Statutes and Rules.

2. CPT Code 99213 rendered on October 14, 2025, was denied with reasons indicating that this service is included in the value of another service provided on the same date. The insurance carrier's response to the dispute also states, "…the office visit was denied as global/inclusive to the program as appropriate."

   CPT Code 99213 is a professional medical service defined as, "Office or other outpatient visits for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making (MDM). When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter."

   28 TAC Section 134.203(b)(1) which applies to disputed CPT code 99213, 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."

   According to a review of the submitted medical bill, on the same date that the requester billed disputed CPT code 99213, the requester also billed time-based CPT codes 97545-WH and 97546-WH, which represent work hardening program services. The work hardening services have been reimbursed by the insurance carrier and are not in dispute.

   Medicare policy strongly supports the position that routine evaluation, monitoring,

progression, supervision, and reassessment performed as part of a work hardening program are **integral components** of the therapy service. Therefore, an evaluation and management service is separately payable only if the service addresses a distinct clinical issue involving separate medical decision-making beyond therapy management, is appended with modifier "25", and is supported by clear documentation.

DWC finds that the usual documentation and progress report requirements for reimbursement of work hardening programs should include: the patient's subjective report of his/her response to the previous session, current pain level, any changes in status, the patient's muscle strength, endurance, performance, physical and psychological tolerances, and any program modifications.

A review of the submitted medical report finds that the documentation does not support a clinical issue involving separate medical decision-making beyond therapy management. The submitted medical documentation does not include elements above and beyond what is expected in a daily work hardening progress report. A review of the medical bill finds that the requester did not append disputed CPT code with modifier "25".

DWC finds that the insurance carrier's reason for denial of CPT code 99213 billed on October 14, 2025, is supported.

3. The requester seeks reimbursement for a DWC Form 073 *Work Status Report* (DWC Form 073), billed under CPT code 99080-73 and rendered on October 14, 2025. The insurance carrier denied payment for the DWC Form 073 with denial reason codes P12 and 248, descriptions indicated above. The insurance carrier submitted a previous DWC Form 073 dated September 22, 2025, in support of its denial.

   28 TAC Section 129.5(e)(1) and (2) state, "The doctor, delegated physician assistant, or delegated advanced practice registered nurse shall file the Work Status Report: (1) after the initial examination of the injured employee, regardless of the injured employee's work status; (2) when the injured employee experiences a change in work status or a substantial change in activity restrictions;…"

   A review of the submitted DWC Form 073 dated October 14, 2025, finds insufficient documentation to support that the injured employee experienced a change in activity or restrictions since the previous report dated September 22, 2025. DWC finds no evidence that the Work Status Report was requested by the carrier or the employer.

   DWC finds that the insurance carrier's reason for denial of CPT code 99080-73 is supported.

4. The requester is seeking reimbursement in the total amount of $208.79 for CPT codes 99213 and 99080-73 billed on October 14, 2025. Because the insurance carrier's reasons for denial of both services are supported, reimbursement is not recommended.

   DWC finds that the requester is not entitled to reimbursement for CPT codes 99213 and

99080-73 billed on October 14, 2025.

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	June 25, 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.