



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Rajesh Gutta, DDS. MS

Respondent Name

State Office of Risk Management

MFDR Tracking Number

M4-26-2154-01

Insurance Carrier's Austin Representative

BOX 45 State Of Texas

DWC Date Received

April 1, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
June 16, 2022	99203	\$103.90	\$0.00
June 16, 2022	70486	\$518.56	\$0.00
Total		\$622.46	\$0.00

Requester's Position

"The carrier reduced the reimbursement, citing that the charges exceeded the recommended allowance based on 'usual, customary and reasonable rates' for the geographical area. We argue that the carrier's payment calculation is incorrect and fails to properly reimburse the provider according to the established Texas Workers' Compensation fee schedule and guidelines."

Amount In Dispute: \$622.46

Respondent's Position

"Furthermore, the Office respectfully requests that this dispute be dismissed as it is not eligible for Medical Fee Dispute Resolution. The dispute was not filed within one year from the dates of service of 6/16/2022 under 28 TAC 133.307(c)(1), as the Division's date stamp shows the dispute was received on 4/1/2026."

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:

1. P12 – Workers' compensation jurisdictional fee schedule adjustment. Note: if adjustment is at the claim level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other claim related information REF) If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (Loop 2110 Service Payment information REF) if the regulations apply. To be used for Workers' Compensation only
2. W3 – Reporting purposes only

Issues

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

Findings

1. Requester submitted a medical fee dispute request for reimbursement in the amount of \$622.46 for service billed codes 99203 and 70486 rendered on June 16, 2022. The insurance carrier denied the service with denial reasons listed above (description codes listed above).
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.

- (i) 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.
- (ii) 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, CPT codes 99203 and 70486 were provided on June 16, 2022. The Division received the MFDR request on April 1, 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 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. [Click or tap here to enter text.](#)

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 1, 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.