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

Twin City Fire Insurance Company

MFDR Tracking Number

M4-26-2289-01

Insurance Carrier's Austin Representative

BOX 47 Burns Anderson Jury Brenner & Donovan

DWC Date Received

April 13, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
February 27, 2026	99080	$426.00	$281.00
	Total	$426.00	$281.00

Requester's Position

The requester did not submit a position statement with this request for MFDR. They did submit a document titled, "Request for Reconsideration" dated March 24, 2026 and April 13, 2026 that states, "The above date of service was denied payment due to "requires a modifier code… It does not require a modifier. This is incorrect."

Amount In Dispute: $426.00

Respondent's Position

"The original bill for dos 2/27/26 was received on 3/2/26 under (redacted) and denied as the procedure code is inconsistent with the modifier used or a required modifier is missing. CPT code 99080 requires a modifier."

Response Submitted By: The Hartford

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 133.210 sets out the requirements for medical bill processing by insurance carrier.
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:

- 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.
- 10 – The billed service requires the use of a modifier code.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. What is DWC considering in this medical fee dispute?
2. Is the insurance carrier's denial supported?
3. What rules apply to the reimbursement of the disputed services?
4. Has DWC determined whether reimbursement is due to the requester?

Findings

1. The requester seeks reimbursement of $426.00 for medical documentation provided to a designated doctor, billed under procedure code 99080 for 852 units on February 27, 2026. The insurance carrier denied the charge in its entirety. DWC will review the submitted service

and determine whether reimbursement is warranted.

2. The dispute request concerns reimbursement for copies of medical documentation provided to a designated doctor in connection with a division-ordered examination.
   Neither the explanation of benefits nor the insurance carrier's response to the medical fee dispute resolution request provides sufficient evidence to support the denial of the disputed services. Accordingly, the insurance carrier's denial of payment is not supported by the available documentation and will not be considered in this review.

3. Under 28 TAC Section 134.120(f)(1), reimbursement for copies of medical documentation is $0.50 per page. In documentation dated February 27, 2026, the requester stated that it submitted 852 pages of records and billed 852 units to reflect the number of pages provided to (medicalrecords@genesismms.com).
   The definition of "medical documentation" is set forth in 28 TAC Section 133.210(a), which provides that medical documentation includes medical reports and records such as evaluation reports, narrative reports, assessment reports, progress reports and notes, clinical notes, hospital records, and diagnostic test results.
   Upon review of the submitted records, DWC finds that 290 pages do not meet the definition of medical documentation under 28 TAC Section 133.210(a) and are therefore not eligible for reimbursement. The remaining 562 pages qualify as reimbursable medical documentation.
   Applying the reimbursement rate established by 28 TAC Section 134.120(f)(1), the allowable reimbursement for 562 qualifying pages is $281.00. Accordingly, reimbursement in the amount of $281.00 is recommended.

4. Based on a review of the submitted documentation and applicable fee guidelines, DWC finds that the insurance carrier's denial based on the absence of a modifier is not supported. DWC concludes that reimbursement is warranted and that the requester is entitled to payment in the amount of $281.00, representing reimbursement for 562 qualifying pages at the rate established by the applicable DWC fee guideline.

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 established that reimbursement is due.

Order

Under Texas Labor Code Sections 413.031 and 413.019, DWC has determined the requester is entitled to reimbursement for the disputed services. It is ordered that Twin City Fire Insurance

Company must remit to Peak Integrated Healthcare $281.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC Section 134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 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.