TDI 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

Peak Integrated Healthcare

Respondent Name

XL Specialty Insurance Company

MFDR Tracking Number

M4-26-2338-01

Insurance Carrier's Austin Representative

BOX 19 Flahive Ogden & Latson

DWC Date Received

April 21, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
February 18, 2026	99080	$122.00	$0.00
	Total	$122.00	$0.00

Requester's Position

The requester did not submit a position statement with this request for MFDR. The did submit a document titled, "Request for Reconsideration" that states, "The above date of service was denied payment due to "fee is not covered.": This is incorrect."

Amount In Dispute: $122.00

Respondent's Position

"...DWC Rule 134.210 does not require an insurance carrier to reimburse a provider for copies of records printed and mailed to a designated doctor. Subsection (b) requires the insurance carrier to pay for the records if the insurance carrier request the records. There is no provision which requires the insurance carrier to reimburse a health care provider for records submitted to a designated doctor. In fact, a previous rule, 133.2 which required those reimbursement was repealed in 2006. In conclusion, Respondent does not owe the Requestor for emailing records to the designated doctor."

Response Submitted By: Downs & Stanford, P.C.

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 133.10 sets out the requirements for a complete medical bill.
5. 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:

- 242 – According to the fee schedule, this charge is not covered.
- 254 – The billed service has no allowance in fee schedule/UCR.
- 5213 – Services not payable as documentation does not support the services rendered.
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, o additional allowance appears to be warranted.

Issues

1. What is DWC considering in this medical fee dispute?
2. Has DWC considered the billed charges in previous dispute?

Findings

1. The requester is seeking reimbursement of $122.00 for sending medical documentation to a designated doctor billed with procedure code 99080 for 244 units on date of service February 18, 2026. The insurance carrier denied payment in full. DWC will review this service

for reimbursement.

2. The medical bill submitted with this dispute is related to the injured worker (redacted) for medical records.

   Information known to the Division finds a MFDR request has previously been submitted for these services for this injured worker.

   The documentation submitted did not include a statement from the requester to explain how these services were distinct from the previously disputed service.

   DWC finds no payment 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.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 9, 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.