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

Continental Insurance Co

MFDR Tracking Number

M4-26-2358-01

Insurance Carrier's Austin Representative

BOX 57 Continental Casualty Co

DWC Date Received

April 22, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
February 10, 2026	99080	$96.00	$0.00
	Total	$96.00	$0.00

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 3, 2026 and April 21, 2026 that states, "The above date of service was denied payment due to "requires a modifier code" WE DISAGREE. It does not require a modifier."

Amount In Dispute: $96.00

Respondent's Position

"At this time, Carrier maintains any and all denials as represented in the attached EORs."

Response Submitted By: Law Office of Brian Judis

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:

- 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.
- 96 – Non-covered charge(s).
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 242 – According to the fee schedule, this charge is not covered.
- 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, no additional allowance appears to be warranted.
- 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(s) supported?

3. What rule(s) apply to documentation and reimbursement of medical documentation?

4. Has DWC determined whether reimbursement is due to the requester?

Findings

1. The provider is requesting payment of $96.00 for medical records/documentation sent to a designated doctor on February 10, 2026 (billed under code 99080). The insurance carrier denied payment. The Division of Workers' Compensation (DWC) will review the dispute and decide whether reimbursement is owed.

2. An Explanation of Benefits (EOB) dated February 25, 2026, denied payment, stating: "The billed service requires the use of a modifier." Upon reconsideration, the insurance carrier issued an additional denial, asserting that the charge was non-covered

   28 TAC Section 127.10(a)(1) states, in relevant part, "The treating doctor and insurance carrier must provide the designated doctor copies of all the injured employee's medical records in their possession relating to the medical condition to be evaluated by the designated doctor … (B) The cost of copying must be reimbursed in accordance with §134.120 of this title …"

   DWC finds that the submission of medical records to a designated doctor is a covered service. The insurance carrier did not provide sufficient evidence to establish that the billed service required a modifier. Furthermore, the carrier's assertion that the charge is non-covered is inconsistent with the requirements of 28 TAC Section 127.10(a)(1). Accordingly, the insurance carrier's denial of payment is not supported.

3. 28 TAC Section 134.120(f)(1) states that the reimbursement for copies of medical documentation is $.50 per page. In a document dated February 10, 2026 submitted as evidence, the requester indicated that it submitted "192 pages of medical records."

   The requester billed 192 units to indicate the number of pages of medical documentation; however, the submitted information only indicates communication between Peak employees. Insufficient evidence was found to support the submission of any records to the designated doctor (Patrick J. Downey).

4. Based on the information available at the time of this review, DWC finds that the requester did not provide clear and convincing evidence demonstrating that the medical records associated with the Commissioner's Order were submitted to the designated doctor. Accordingly, the requester has not established entitlement to reimbursement for the billed service. Therefore, no reimbursement is 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	June 10, 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.