



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Steven Reed Anderson DC

**Respondent Name**

Texas Mutual Insurance Co

**MFDR Tracking Number**

M4-25-1266-01

**Carrier's Austin Representative**

Box Number 54

**DWC Date Received**

February 7, 2025

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 7, 2024	99456 W5 NM	\$449.00	\$0.00
June 7, 2024	99456 W6	\$642.00	\$0.00
June 7, 2024	99456 W7	\$642.00	\$0.00
<b>Total</b>		<b>\$1,733.00</b>	<b>\$0.00</b>

### Requestor's Position

"DESIGNATED DOCTOR EXAM", "THE CURRENT RULES ALLOW REIMBURSEMENT", "AN ORIGINAL BILL AND A RECONSIDERATON WERE SUBMITTED, THE CURRENT RULES ALLOW REIMBURSEMENT."

**Amount in Dispute:** \$1,733.00

### Respondent's Position

"The date of exam on the bill and DWC-69 reflect 06/07/2024 the date on the narrative reflects the date of 06/18/2024. Per TAC rule 130.1(d)(B)(i), the report of medical evaluation includes an attached narrative report. The narrative report must include the following: date of the certifying examination. Our position is that no payment is due."

**Response Submitted by:** Texas Mutual

## Findings and Decision

### Authority

This medical fee dispute is decided according to [Texas Labor Code \(TLC\) §413.031](#) and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

### Statutes and Rules

1. [28 Texas Administrative Code \(TAC\) §134.240](#) sets out the procedures billing and reimbursement of designated doctor examinations.
2. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.
3. [28 TAC §130.1](#) sets out the requirements of certification of maximum medical improvement and evaluation.

### Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- All documents HCFA/DWC-69/documentation should all reflect the same date of service.
- A26 – For further review of reimbursement, clarify rendering provider and date of exam between the exam report &/or DWC69.
- CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- CAC-93 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- DC4 – No additional reimbursement allowed after reconsideration
- 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

### Issues

1. Is the insurance carrier's denial supported?

### Findings

1. The requestor is seeking reimbursement for a designated doctor exam performed on June 7, 2024. The insurance carrier denied payment, in part, stating, "For further review of reimbursement, clarify rendering provider and date of exam between the exam report &/or DWC69," and "All documents HCFA/DWC-69/documentation should all reflect the same date of service."

DWC Rule 28 TAC §130.1(d)(1) states, in relevant part, "Certification of MMI, determination of

permanent impairment, and assignment of an impairment rating (if permanent impairment exists) for the current compensable injury requires completion, signing, and submission of the Report of Medical Evaluation and a narrative report ... (B) The Report of Medical Evaluation includes an attached narrative report. The narrative report must include the following: (i) date of the certifying examination."

The bills and Report of Medical Evaluation (DWC069) submitted with the request for medical fee dispute resolution indicate that the date of service was June 7, 2024. The attached narrative report indicates that the date service was performed on June 18, 2024.

Because the documentation does not support the billed date of service, DWC cannot recommend reimbursement for the examination in question.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requestor has not established that reimbursement is due.

**Order**

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to \$0.00 reimbursement for the disputed services.

**Authorized Signature**

\_\_\_\_\_  
Signature

Medical Fee Dispute Resolution Officer

March 10, 2025  
\_\_\_\_\_  
Date

**Your Right to Appeal**

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §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](http://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 1-800-252-7031, option three or email [CompConnection@tdi.texas.gov](mailto: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 the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in [28 TAC §141.1 \(d\)](#).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción tres o correo electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).