



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Tex-Cal Medical Services

**Respondent Name**

Great American Alliance Insurance Co

**MFDR Tracking Number**

M4-25-1296-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

February 11, 2025

### Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due     |
|------------------|-------------------|-------------------|----------------|
| January 7, 2025  | 99456-NM          | \$19.00           | \$19.00        |
| January 7, 2025  | 99456-W8          | \$19.00           | \$19.00        |
| <b>Total</b>     |                   | <b>\$38.00</b>    | <b>\$38.00</b> |

### Requestor's Position

The requestor did not submit a position statement with this request for MFDR.

**Amount in Dispute:** \$38.00

### Respondent's Position

"Carrier received notice of fee dispute file by Tex-Cal Med Services... Additional pursuant to Rule 134.240 Carrier believes the payment was issued correctly for services rendered..."

**Response Submitted by:** Strategic Comp

## 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 benefits – guidelines for medical services, charges and payment for designated doctor visits.
2. [28 Texas Administrative Code \(TAC\) §134.210](#) defines the medical fee guideline for Workers' Compensation Specific Services.
3. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.

### Denial Reasons

Neither party submitted explanations of benefits that detail adjudication reason codes. The respondent submitted a copy of the check in support of the amount paid.

### Issues

1. What rule is applicable to reimbursement?

### Findings

This dispute involves a designated doctor exam performed on January 7, 2024. DWC Rule §134.210 sets out the updated medical fee guidelines for workers' compensation specific services and states, "(4) Fees established in §§134.235, 134.240, 134.250, and 134.260 of this title will be: (A) adjusted once by applying the Medicare Economic Index (MEI) percentage adjustment factor for the period 2009 - 2024. (B) adjusted annually by applying the MEI percentage adjustment factor identified in §134.203(c)(2). (C) rounded to whole dollars by dropping amounts under 50 cents and increasing amounts from 50 to 99 cents to the next dollar. For example, \$1.39 becomes \$1 and \$2.50 becomes \$3. (D) effective on January 1 of each new calendar year."

DWC Rule §134.240 details the guidelines for designated doctor examinations. This rule was updated to be effective June 1, 2024. The fees associated with this date of service are found at 28 TAC §134.240 and at, <https://www.tdi.texas.gov/wc/fee/conversionfactors.html#examfees>.

1. The submitted medical bill for date of service January 7, 2025 contained the following.
  - 99456 – NM (designated doctor exam MMI evaluation, MMI has not been reached).
  - 2025 reimbursement rate \$465.00

- 99456– W8 (Return to work)
  - 2025 reimbursement rate \$664.00
- Total reimbursement for disputed services, \$1,129.00
- A copy of the front of a check submitted by the respondent indicates payment in the amount of \$1,091. The remaining balance of \$38.00 is due to the requester.

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 established that additional reimbursement is due.

**Order**

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that Great American Alliance Insurance Co must remit to Tex-Cal Medical Services \$38.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

**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).