



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Marcus Hayes, D.C.

Respondent Name

American Zurich Insurance Co.

MFDR Tracking Number

M4-25-1935-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

April 19, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 10, 2025	Examination to Determine Maximum Medical Improvement and Impairment Rating – 99455-V4, 1 unit	\$265.17	\$0.00

Requester's Position

"Regarding the reduction in payment, Sedgwick remitted payment for the 'V4' level MMI assessment and not for the IR determination. On reconsideration, the carrier remitted \$119.83 for the IR determination and not the \$385.00 requested."

Amount in Dispute: \$265.17

Respondent's Position

The Austin carrier representative for American Zurich Insurance Co. is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on April 29, 2025.

Per 28 Texas Administrative Code §133.307(d)(1), if DWC does not receive the response within 14 calendar days of the dispute notification, then DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We

will base this decision on the information available.

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 \(TAC\) §133.307](#) sets out the procedures for resolving medical fee disputes.
2. [28 TAC §134.250](#) sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating by a treating doctor.
3. [28 TAC §134.260](#) sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating by a referred doctor.

Denial Reasons

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

- 309 – The charge for this procedure exceeds the fee schedule allowance.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- N600 – Adjusted based on the applicable fee schedule for the region in which the service was rendered.
- 1002 – Due to an error in processing the original bill, we are recommending further payment be made for the above noted procedure.
- 2008 – Additional payment made on appeal/reconsideration.

Issues

1. Is Marcus Hayes, D.C. entitled to additional reimbursement?

Findings

1. Dr. Hayes is seeking reimbursement for an examination to determine maximum medical improvement and impairment rating performed on March 10, 2025. Dr. Hayes submitted documentation indicating that he was acting in the role of a doctor selected by the treating doctor acting in place of a treating doctor. This role must be referred by the treating doctor for the examination in question.

In his position statement, Dr. Hayes quoted 28 TAC §134.250 to support the requested reimbursement amount. However, as a doctor referred by the treating doctor, the appropriate fee guidelines are found in 28 TAC §134.260, which state, in relevant part:

(c) The following applies for billing and reimbursement of an MMI or IR evaluation by a referred doctor.

(1) CPT code. The referred doctor must bill using CPT code 99456 with the appropriate modifier.

(2) MMI. MMI evaluations will be reimbursed at \$449 adjusted per §134.210(b)(4).

(3) IR. For IR examinations, the referred doctor must bill, and the insurance carrier must reimburse, the components of the IR evaluation. Indicate the number of body areas rated in the units column of the billing form.

DWC finds that Dr. Hayes failed to bill the services in question in accordance with the relevant fee guidelines. Therefore, no additional reimbursement can be recommended.

Conclusion

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

DWC finds the requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§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

July 17, 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. 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.

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.