



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Edward W. Smith, D.O.

Respondent Name

Great West Casualty Co.

MFDR Tracking Number

M4-25-1946-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

April 21, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 23, 2024	Designated Doctor Examination 99456-W5	\$449.00	\$449.00
	Designated Doctor Examination 99456-W5	\$192.00	\$192.00
Total		\$641.00	\$641.00

Requester's Position

"All submitted charges and coding conform to DWC Rules 28 TAC Chapter 134.

The original claim form was properly coded and submitted in a timely fashion to the carrier."

Amount in Dispute: \$641.00

Respondent's Position

The Austin carrier representative for Great West Casualty 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 §134.240](#) sets out the fee guidelines for designated doctor examinations.

Denial Reasons

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

- TX18 – Exact duplicate claim/service.
- 247 – A payment or denial has already been recommended for this service.

Issues

1. Is the insurance carrier's denial based on duplicate claim/service supported?
2. Is Edward W. Smith, D.O. entitled to reimbursement?

Findings

1. Dr. Smith is seeking reimbursement for a designated doctor examination to determine maximum medical improvement and impairment rating for a non-musculoskeletal body area performed on September 23, 2024. The insurance carrier denied payment stating that it was an "exact duplicate claim/service," and "a payment or denial has already been recommended for this service." DWC found no evidence to support this denial.
2. Because the insurance carrier failed to support its denial of payment for the services in question, DWC finds that Dr. Smith is entitled to reimbursement as follows.

28 TAC §134.240(d)(3) states, in relevant part, "MMI evaluations will be reimbursed at \$449 adjusted per §134.210(b)(4)." No adjustments found in 28 TAC §134.210(b)(4) apply for the date of service in question.

28 TAC §134.240(d)(4)(B)(iii) states, in relevant part, "The reimbursement for the assignment of an IR in a non-musculoskeletal body area is \$192 adjusted per §134.210(b)(4)." No adjustments found in 28 TAC §134.210(b)(4) apply for the date of service in question.

The total allowable reimbursement for the services in question is \$641.00. The amount is 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 established that reimbursement of \$641.00 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to reimbursement for the disputed services. It is ordered that Great West Casualty Co. must remit to Edward W. Smith, D.O. \$641.00 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

July 25, 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.