



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Robert John Wolff, DC

**Respondent Name**

Hartford Fire Insurance Co

**MFDR Tracking Number**

M4-25-2108-01

**Carrier's Austin Representative**

Box Number 47

**DWC Date Received**

May 5, 2025

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 5, 2025	Designated Doctor Examination 99456 W6	\$664.00	\$664.00

### Requestor's Position

"The EOI portion was not reimbursed and according to the reasoning on the EOB 'Not a work-related injury/illness and thus not the liability of the workers' compensation carrier.' Also, 'This billing is for a service unrelated to the work illness or injury.'"

Supplement response submitted May 29, 2025

"The extent of injury can't be denied based upon 'partial denial as unrelated...'"

**Amount in Dispute:** \$664.00

### Respondent's Position

"The bill was processed and paid per DDE outline with a partial denial as unrelated. ...Nothing further is warranted."

**Response submitted by:** The Hartford

## 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 billing requirements and reimbursement guidelines for designated doctor examinations.
2. [TLC 408.0041](#) sets out requirements of designated doctor examinations.
3. [28 TAC 134.210](#) sets out the medical fee guideline for workers' compensation specific services.
4. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.

### Denial Reasons

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

- P2 – Not a work-related injury/illness and thus not the liability of the workers' compensation carrier.
- 269 – This billing is for a service unrelated to the work illness or injury.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 4150 – An allowance has been paid for a designated doctor examination as outlined in 134.204(J) for attainment of maximum medical improvement. An additional allowance is payable if a determination of the impairment caused by the compensable injury was also performed.

### Issues

1. Is the insurance carrier's denial supported?
2. What rule is applicable to reimbursement?

### Findings

1. Dr Wolff is seeking reimbursement for a DWC ordered designated doctor to determine extent of injury for date of service March 5, 2025 billed as 99456 -W6. The insurance carrier denied the service as being unrelated. Review of the "Request for designated doctor examination" (DWC 32) indicates Extent of injury – "(redacted)."

TLC 408.0041 (h) states, "The insurance carrier shall pay for: (1) an examination required under Subsection (a), (f), or (f-2), unless otherwise prohibited by this subtitle or by an order or rule of the commissioner; The DWC 32 mentioned above included an order for extent of injury. The insurance carrier's denial is not supported.

2. DWC Rule 28 TAC §134.240 (d) (5) states, "Extent of injury. The reimbursement rate for determining the extent of the employee's compensable injury is \$642 adjusted per §134.210(b)(4), and the designated doctor must apply the additional modifier "W6."

DWC Rule 28 TAC §134.210 (b)(4) states, "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 (after the initial adjustment) 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.

The exam fees listed on the Texas Department of Insurance at [www.tdi.texas.gov/wc/fee](http://www.tdi.texas.gov/wc/fee) indicate a payment amount of \$664.00 for Extent-of-injury exam by RME or DD for dates of services January 1, 2025 – December 31, 2025. This amount is recommended.

### 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 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 Hartford Fire Insurance Co must remit to Robert John Wolff DC., \$664.00 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

June 5, 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).