



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requester Name**

Ursula Funderburk, D.C.

**Respondent Name**

Everest National Insurance Co.

**MFDR Tracking Number**

M4-25-2194-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

May 12, 2025

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 9, 2024	Designated Doctor Examination 99456-W5	\$449.00	\$449.00
	Designated Doctor Examination 99456-W5	\$577.00	\$577.00
<b>Total</b>		<b>\$1,026.00</b>	<b>\$1,026.00</b>

### Requester's Position

"These services were requested and prescribed by the Division. The above referenced designated doctor performed the MMI examination and assigned the IR, that means he should bill using the appropriate MMI CPT code 99456."

**Amount in Dispute:** \$1,026.00

### Respondent's Position

The Austin carrier representative for Everest National Insurance Co. is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on May 20, 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.
3. [TLC §408.0041](#) provides the requirements for designated doctor examinations.

### Denial Reasons

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

- V – Unnecessary treatment (w/peer review)
- D51 – Unnecessary treatment based on peer review
- P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies
- D00 – Based on further review, no additional allowance is warranted.

### Issues

1. Is the insurance carrier's denial based on necessary treatment supported?
2. Is Ursula Funderburk, D.C. entitled to reimbursement for the services in question?

### Findings

1. Dr. Funderburk is seeking reimbursement for a designated doctor examination to determine maximum medical improvement and impairment rating. The insurance carrier denied payment stating, "unnecessary treatment based on peer review."

DWC finds that Dr. Funderburk was ordered by the commissioner to perform a designated doctor examination to determine maximum medical improvement and impairment rating in accordance with TLC §408.0041(a).

TLC §408.0041(h) requires the insurance carrier to reimburse designated doctor examinations unless otherwise prohibited by statute, order, or rule. The insurance carrier submitted no evidence to support that reimbursement for the examination in question was prohibited.

DWC finds that the insurance carrier's denial of payment for unnecessary treatment is not supported.

2. Because the insurance carrier failed to support its denial of payment for the services in question, DWC finds that Dr. Funderburk 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)."

28 TAC §134.240(d)(4)(A) states, in relevant part, "For musculoskeletal body areas, the designated doctor may bill for a maximum of three body areas.

- (i) Musculoskeletal body areas are:
  - (I) spine and pelvis;
  - (II) upper extremities and hands; and
  - (III) lower extremities (including feet).
- (ii) For musculoskeletal body areas:
  - (I) the reimbursement for the first musculoskeletal body area is \$385 adjusted per §134.210(b)(4); and
  - (II) the reimbursement for each additional musculoskeletal body area is \$192 adjusted per §134.210(b)(4)."

The doctor certified IR for the spine and upper extremity. The maximum allowable reimbursement for this service is \$577.00.

DWC finds that the total allowable reimbursement for the examination in question is \$1,026.00. This 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 \$1,026.00 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 Everest National Insurance Co. must remit to Ursula Funderburk, D.C. \$1,026.00 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

\_\_\_\_\_  
August 15, 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).