



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Stephanie Janiak

Respondent Name

Alaska National Insurance Co

MFDR Tracking Number

M4-25-2893-01

Carrier's Austin Representative

Box Number 17

DWC Date Received

July 14, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 26, 2024	99456-NM	\$449.00	\$0.00
June 26, 2024	99456-W8	\$642.00	\$0.00
	Total	\$1091.00	\$0.00

Requestor's Position

No position statement submitted with this request for MFDR.

Amount in Dispute: \$1091.00

Respondent's Position

"The Requestor's bill has now been processed and includes interest from 7/5/2024 (7/4/2024 = holiday) for DOS 6=06/26/24. A copy of the EOR is attached and the payment information is below."

Response Submitted by: CorVel

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 §134.260](#) sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating performed by referred doctors.

Denial Reasons

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

- NM – Not at maximum medical improvement
- W8 – Designated Doctor Examination for Return to Work

Issues

1. Did the respondent support payment made at requested amount?

Findings

1. Dr. Janiak is seeking reimbursement for an examination to determine maximum medical improvement (MMI), and return to work.

DWC finds that the submitted documentation supports that Corvel made a payment of \$1,169.93 (requested amount plus interest) on August 13, 2025 via check 6007600 which cleared on August 14, 2025. As the services were paid at the requested amount plus interest no additional payment 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 not established that additional reimbursement of is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Officer

November 21, 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.