TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Stephanie Janiak, D.C.

Respondent Name

Retailers Casualty Insurance

MFDR Tracking Number

M4-25-2932

Insurance Carrier's Austin Representative

BOX 17 Downs Stanford PC

DWC Date Received

July 17, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
August 22, 2024	Designated Doctor Examination 99456-W5	$834.00	$0.00
	Total	$834.00	$0.00

Requester's Position

"A designated doctor's examination was performed … 8/22/2024 and the final report, HFCA, and 69 were faxed … on 9/5/2024."

Amount In Dispute: $834.00

Respondent's Position

"The Carrier has issued payment of the medical bill in full."

Response Submitted By: Downs Stanford, P.C.

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code Section 413.031 and other applicable laws and rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) Section 133.307 sets out the procedures for resolving medical fee disputes.

Adjustment Reasons

The insurance carrier issued payment for the services in question with the following reasons:

1. A10 – Payment made pursuant to pre-agreed amount

Issues

1. What is DWC considering in this medical fee dispute?
2. Is the requester entitled to additional reimbursement?

Findings

1. The requester is seeking reimbursement for a designated doctor examination to determine maximum medical improvement and impairment rating performed on August 22, 2024. In the request, Dr. Janiak indicated that no reimbursement was received. This is the service that will be reviewed in this dispute.

2. Explanation of benefits submitted by the insurance carrier dated July 22, 2025, indicates that it paid the requested amount in full. No additional reimbursement is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence requester and the respondent presented 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 Sections 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	February 13, 2026 Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC Section 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 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 this *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC Section 141.1(d).

Si prefiere hablar con una persona en español acerca de esta correspondencia, favor de llamar a 800-252-7031, opción tres o correo electronico CompConnection@tdi.texas.gov.