



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Keith Louden, M.D.

Respondent Name

Accident Fund General Insurance

MFDR Tracking Number

M4-25-3342-01

Carrier's Austin Representative

Box Number 06

DWC Date Received

August 20, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 17, 2024	Designated Doctor Examination – 99456-W5	\$0.00	\$0.00
	Designated Doctor Board Certification Required – 99456-25	\$300.00	\$0.00
Total		\$300.00	\$0.00

Requester's Position

"THE CURRENT RULES ALLOW REIMBURSEMENT"

Amount in Dispute: \$300.00

Respondent's Position

"ICD-10-CM codes reported with this billing reflect MMI/IR assessment ... Documentation submitted with these charges does not reflect any of the diagnoses required to support modifier -25."

Response Submitted by: Stone Loughlin Swanson

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 \(TAC\) §127.130](#) sets out the qualification requirements for designated doctor examinations.
2. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.
3. [28 TAC §134.240](#) sets out the fee guidelines for designated doctor examinations.

Denial Reasons

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

- FR07 – Item is not supported by this procedure type or documentation supplied by your facility.
- TX W3 – The Benefit for this service is included in the payment/allowance for another service/procedure that has been performed on the same day.
- @G(W3) – No additional reimbursement allowed after review of appeal/reconsideration.
- CCOR – Provider submitted a corrected bill

Issues

1. What services are considered in this dispute?
2. Is Keith Louden, M.D. entitled to reimbursement for the fee in question?

Findings

1. Dr. Louden is seeking additional reimbursement for an examination to determine maximum medical improvement and impairment rating, represented by procedure code 99456-W5 and a fee to indicate that the examination required a board-certified physician represented by procedure code 99456-25.

Dr. Louden is seeking \$0.00 for code 99456-W5. Therefore, this code will not be considered in this dispute. The requester is seeking \$300.00 for code 99456-25. This is the service considered in this dispute.

2. Per 28 TAC §134.240(g), "When the division orders the designated doctor to perform an examination of an injured employee with one or more of the diagnoses listed in §127.130(b)(9)(B) - (I) of this title:

- (1) The designated doctor must add modifier "25" to the appropriate examination code.
- (2) The designated doctor must add modifier "25" once per bill when addressing issues on the same day, regardless of the number of diagnoses or the number of issues the division ordered the designated doctor to examine.
- (3) The designated doctor must bill, and the insurance carrier must reimburse \$300 adjusted per §134.210(b)(4) in addition to the examination fee.

DWC finds that the documentation submitted failed to demonstrate that the injury evaluated in this examination included any of the diagnoses in 28 TAC §127.130(b)(9)(B) - (I), requiring a board-certified physician. Therefore, Dr. Louden is not entitled to reimbursement for this fee.

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 not established that additional reimbursement is due.

Order

Under Texas Labor Code §§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	September 30, 2025 Date
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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.