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
David Teuscher, M.D.

Respondent Name
Old Republic Insurance Company

MFDR Tracking Number
M4-26-0026-01

Carrier's Austin Representative
Box Number 44

DWC Date Received
September 3, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 26, 2024	99456-W5	$1,218.00	$1,218.00
August 26, 2024	99456-W6	$642.00	$0.00
	Total	$1,860.00	$1,218.00

Requester's Position

"CARRIER IS REQUIRED TO PAY DESIGNATED DOCTOR EXAMS."

Amount in Dispute: $1,860.00

Respondent's Position

The Austin carrier representative for Old Republic Insurance is White Espey, PLLC. The representative was notified of this medical fee dispute on September 5, 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 §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 Medical Fee Dispute Resolution (MFDR) requests.
2. 28 TAC §134.240 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.
3. 28 TAC §134.210 sets out the medical fee guideline for Workers' Compensation specific services.
4. Texas Labor Code §408.0041 sets out regulations regarding Designated Doctor Examinations.

Adjustment Reasons

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

- 4271 - PER TX LABOR CODE SEC. 408.027, PROVIDERS MUST SUBMIT BILLS TO PAYORS WITHIN 95 DAYS OF THE DATE OF SERVICE.
- 29 – THE TIME LIMIT FOR FILING CLAIM/BILL HAS EXPIRED.
- 247 - A PAYMENT OR DENIAL HAS ALREADY BEEN RECOMMENDED FOR THIS SERVICE.
- 18 – EXACT DUPLICATE CLAIM/SERVICE.

Issues

1. What rules apply to the services in dispute?
2. Is the insurance carrier's denial reason supported?

3. Is the requester entitled to reimbursement for the services in dispute?

Findings

1. This medical fee dispute involves an examination by a designated doctor for the purpose of establishing: if maximum medical improvement (MMI) has been reached; what date MMI was reached if applicable, and to provide impairment ratings (IR) if MMI has been reached.

   On the disputed date of service, the requester billed a total amount of $1,860.00 for CPT code 99456-W5 and CPT code 99456-W6. CPT code 99456 indicates the service of a MMI and/or IR examination by a doctor other than the treating doctor. Modifier W5 indicates the examination was performed by a designated doctor. Modifier W6 indicates a determination of the extent of the compensable injury.

   DWC finds that 28 TAC §134.240, adopted to be effective June 1, 2024, applies to the reimbursement of the services in dispute. 28 TAC §134.240 (d), states in pertinent part,

   (d) When conducting a designated doctor examination, the designated doctor must bill, and the insurance carrier must reimburse, using CPT code 99456 and with the modifiers and rates specified in subsections (d)(1) - (7)…
   (2) (C) If the designated doctor determines MMI has been reached and an IR evaluation is performed, both the MMI evaluation and the IR evaluation portions of the examination must be billed and reimbursed in accordance with subsection (d) of this section.
   (3) MMI. MMI evaluations will be reimbursed at $449 adjusted per §134.210(b)(4), and the designated doctor must apply the additional modifier "W5."
   (4) IR. For IR examinations, the designated doctor must bill, and the insurance carrier must reimburse the components of the IR evaluation. The designated doctor must apply the additional modifier "W5." Indicate the number of body areas rated in the unit's column of the billing form.
   (A) 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; (musculoskeletal structures of torso)
   (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).

(B) For non-musculoskeletal body areas, the designated doctor must bill, and the insurance carrier must reimburse, for each non-musculoskeletal body area examined.

(i) Non-musculoskeletal body areas are defined as follows:

(I) body systems;

(II) body structures (including skin); and

(III) mental and behavioral disorders.

(ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides.

(iii) The reimbursement for the assignment of an IR in a non-musculoskeletal body area is $192 adjusted per §134.210(b)(4).

(5) 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 finds that 28 TAC §134.210 applies to the annual fee adjustment of the disputed services, stating in pertinent part, "(b)(4) 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 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."

DWC finds that Texas Labor Code §408.0041, subsection (a) gives the commissioner the right to order an exam to answer specific questions and subsection (h)(1) limits the insurance carrier's liability of reimbursement to the issues ordered by the commissioner, stating,

(a) At the request of an insurance carrier or an employee, or on the commissioner's own order, the commissioner may order a medical examination to resolve any question about:

(1) the impairment caused by the compensable injury;

(2) the attainment of maximum medical improvement;

(3) the extent of the employee's compensable injury;

(4) whether the injured employee's disability is a direct result of the work-related injury;

(5) the ability of the employee to return to work; or

(6) issues similar to those described by Subdivisions (1)-(5)…

(h) 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;

2. A review of the submitted explanation of benefits (EOB) dated December 26, 2024, finds that the insurance carrier denied payment for the disputed services based on untimely filing of the medical bill.

   In accordance with 28 TAC 134.240 (e)(1-2), If a designated doctor refers an injured employee for additional testing or evaluation, the 95-day period for timely submission of the designated doctor bill for the examination begins on the date of service of the additional testing or evaluation and the dates of service (CMS-1500/field 24A) are as follows: the "From" date is the date of the designated doctor examination, and the "To" date is the date of service of the additional testing or evaluation.

   A review of the submitted medical record finds that the requester, a designated doctor, referred the injured worker for additional required testing which was completed as of December 4, 2024. A review of the medical bills submitted supports that the dates of service in field 24A of the CMS-1500 medical bill range from August 26, 2024, to December 4, 2024.

   According to the review of the submitted medical reports and the submitted medical bills, the disputed date of service range is August 26, 2024, to December 4, 2024. The EOBs submitted support that the medical bill was first received by the insurance carrier on December 26, 2024, less than 95 days past the date of service the additional testing was completed.

   DWC finds that the insurance carrier's reason for denial of the services in dispute is not supported. Therefore, the disputed services will be reviewed for the maximum allowable reimbursement (MAR) in accordance with DWC statutes and rules.

3. The requester, a designated doctor, is seeking reimbursement in the amount of $1,860.00 for an examination to determine MMI and IR as well as the extent of the injured worker's injuries, rendered on August 26, 2024, with additional referred testing completed on December 4, 2024.

   A review of the submitted medical report supports that Dr. Teuscher, a designated doctor, performed an examination of MMI as ordered by DWC. Per 28 TAC §134.240 (d), the

maximum allowable reimbursement (MAR) for this examination is $449.00 on the disputed date of service.

A review of the submitted medical record also finds that the requester performed IR evaluations of three musculoskeletal body areas. The rule at 28 TAC §134.240 defines the fees for the calculation of an IR for musculoskeletal body areas. The MAR for the evaluation of the first musculoskeletal body area is $385.00 on the disputed date of service. The MAR on the disputed date of service for each additional musculoskeletal body area is $192.00.

A review of the submitted medical record additionally finds that the requester performed an IR evaluation of one non-musculoskeletal body area. The rule at 28 TAC §134.240 defines the fees for the calculation of an IR for non-musculoskeletal body areas. The MAR for the evaluation of one non-musculoskeletal body area is $192.00 on the disputed date of service.

A review of the submitted medical reports and medical bill finds that the designated doctor performed and charged $642.00 for an examination to determine the injured worker's extent of compensable injuries. In accordance with Texas Labor Code §408.0041, the insurance carrier is only liable for the reimbursement of designated doctor examinations to address issues ordered by the commissioner. DWC finds no evidence to support that determination of extent of injury was requested or ordered by the commissioner.

In accordance with 28 TAC §134.240, the reimbursements which apply to the disputed examination rendered on August 26, 2024, are:

- For an MMI examination, reimbursement is $449.00.
- For IR of one non-musculoskeletal body area, reimbursement is $192.00.
- For IR of three musculoskeletal body areas, reimbursement is $769.00.
- DWC finds that the total MAR for the examination in question is $1,410.00.
- The insurance carrier paid $0.00 as of the date of this review.
- The requester is seeking $1,218.00 for the services of MMI and IR.
- Reimbursement in the total amount of $1,218.00 is recommended.

DWC finds that reimbursement in the amount of $1,218.00 is due for the services in dispute.

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 in the amount of $1,218.00 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 Old Republic Insurance Company must remit to David Teuscher, M.D. $1,218.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature:

		December 30, 2025
Signature	Medical Fee Dispute Resolution Officer	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 3 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 3 o correo electronico CompConnection@TDI.Texas.gov