TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name
David West, D.O.

Respondent Name
Arch Insurance Co

MFDR Tracking Number
M4-26-1362-01

Carrier's Austin Representative
Box 19 Flahive Ogden & Latson

DWC Date Received
January 15, 2026

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 29, 2025	Examination to Determine MMI – 99456	$465.00	$0.00
	Total	$465.00	$0.00

Requester's Position

"JOSE FUENTES IS THE TREATING DOCTOR AND REFERRED THE PATIENT FOR A POST DEISGNATED DOCTOR EXAM."

Amount in Dispute: $465.00

Respondent's Position

The Austin carrier representative for Arch Insurance Co. is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on January 16, 2026.

Per 28 Texas Administrative Code Section 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) Section 133.305 sets out the procedures for resolving medical disputes.

2. 28 TAC Section 133.307 sets out the procedures for resolving medical fee disputes.

3. The Texas Insurance Code (TIC) Chapter 1305 sets out the general provisions for workers' compensation health care networks.

4. 28 TAC Sections 10.120 through 10.122 sets out the workers compensation health care networks complaints guidelines.

5. 28 TAC Section 141.1 sets out the guidelines for dispute resolution—benefit review conference.

Denial Reasons

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

- 90147(109) – Claim not covered by this payer/contractor. You must sent the claim to the correct payer/contractor.
- ZK10 – Resolution Manager Denial.
- 243 – Services not authorized by network/primary care providers.
- 16 – Claims/services lacks information which is needed for adjudication.
- Comment: "Referring doctor is not testing doctor to refer claimant."

Issues

1. Were the disputed services provided by the requester out-of-network healthcare?
2. Is the insurance carrier liable for the out-of-network healthcare in this case?

Findings

1. The requester, David West, D.O., submitted medical fee dispute M4-26-1362-01 to DWC for resolution under 28 TAC Section 133.307. The dispute involves an examination to determine if the injured employee had reached maximum medical improvement (MMI) by a doctor referred by the treating doctor performed on September 29, 2025.

Based on the documentation submitted and information available to DWC, the injured employee's claim is subject to the Coventry Healthcare Certified Network. At the time the services were rendered, the requester was not a participating provider in this certified network. Therefore, the services were provided on an out-of-network basis.

The requester contends that "JOSE FUENTES IS THE TREATING DOCTOR AND REFERRED THE PATIENT FOR A POST DEISGNATED DOCTOR EXAM" and asserts that this entitles him to reimbursement under the Texas Labor Code and applicable DWC rules. DWC has jurisdiction to review and resolve medical fee disputes of this nature.

2. The requester seeks reimbursement pursuant to the Texas Labor Code and applicable regulations, including 28 TAC Section 133.307. Liability for out-of-network care is governed by TIC Section 1305.006, which specifies the limited circumstances under which an insurance carrier is responsible for such care. Those circumstances are limited to:

    - Emergency care;
    - Care provided to an employee residing outside any network service area; and
    - Care delivered by an out-of-network provider following a network-approved referral under TIC Section 1305.103.

    DWC found no supporting documentation substantiating that the services qualified as emergency care. Therefore, the supporting documentation was insufficient to substantiate a claim under this provision.

    DWC found no evidence that the injured employee resided outside the network's service area. Consequently, the requirements to establish liability under this subsection were not satisfied.

    DWC found no documents confirming an out-of-network request was submitted and approved. Thus, the criteria for liability under this subsection was not met.

Conclusion

After careful consideration of the submitted documentation, DWC concludes that the requester has not met the burden of proof to establish that the disputed services qualify under any of the circumstances outlined in TIC Section 1305.006. Specifically:

- No evidence was provided to support a claim of emergency care.
- No documentation demonstrated that the injured employee resided outside the network's service area; and
- No network-approved out-of-network referral was presented.

Accordingly, the requester has not shown that the insurance carrier is liable for payment of the out-of-network services. Therefore, the dispute is resolved in favor of the insurance carrier.

Order

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the DWC hereby determines that the requester is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 18, 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 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 Section 141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.