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

General Information

Requestor Name
Mark R. Bronson, D.C.

Respondent Name
Insurance Company of the West

MFDR Tracking Number
M4-25-0275-01

Carrier's Austin Representative
Box Number 04

DWC Date Received
October 1, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 19, 2024	Designated Doctor Examination	$385.00	$385.00

Requestor's Position

"The report and billing were produced and faxed to the carrier per TAC Rule §134.240 … Check number 5508809 was received on September 5th in the amount of $1219.00 reduced by $385.00. This is the amount of the IR which is clearly on the order to address … A reconsideration was sent to the adjuster on September 5, 2024 with an explanation of TAC Rule §134.240 showing a breakdown of each fee and the total reimbursement for this service. Mitchell International is advising the carrier their original review was appropriate and unable to recommend additional allowance. I disagree with the position Mitchell International is taking …"

Amount in Dispute: $385.00

Respondent's Position

"In review of the original received billing on 07/27/2024 for date of service 07/19/2024, the bill was paid per billing. Below are the details of the submitted bill and the supporting labor code Title 28, Part 2, Chapter 134, Subchapter C, Rule §134.240 for allowance per line item.

- Line 1 – Provider billed 99456-W5 with 1 unit in the amount of $834.00, bill reduced to $449.00

    - Labor code (3) MMI evaluations will be reimbursed at $449 adjusted per §134.210(b)(4), and the designated doctor must apply the additional modifier 'W5.'
- Line 2 – Provider billed 99456-W5-MI with 2 units in the amount of $128.00, allowance in full.
    - Labor code (E) When the division requires the designated doctor to complete multiple IR calculations, the designated doctor must apply the additional modifier 'MI.'
    - Labor code (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).
- Line 3 – Provider billed 99456-W6 with 1 unit in the amount of $642.00, allowance in full.
    - Labor Code (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.'

"In review of the submitted billing the provider overbilled on line 1 and under billed on line 2 per the labor code. Allowance was made per the submitted billing in accordance with Rule §134.240."

Response Submitted by: ICW Group Insurance Companies

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 §134.210, effective June 1, 2024, 49 TexReg 1489, provides the fee guidelines for workers' compensation specific services.

3. 28 TAC §134.240, effective June 1, 2024, 49 TexReg 1489, 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:

- G15 – Pricing is calculated based on the medical professional fee schedule value.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- Notes – "We have re-evaluated the submitted documentation and feel that our

original review was appropriate. Amount rendered is equal or exceeds the payment required under the Texas Workers' Compensation Act statutory standard for payment for medical provider. In review of this, we are unable to recommend any additional allowance."

Issues

1. Is Mark R. Bronson, D.C. entitled to additional reimbursement for the services in question?

Findings

1. Dr. Bronson is seeking additional reimbursement for a designated doctor examination to determine maximum medical improvement, impairment rating, and the extent of the compensable injury, with multiple impairment rating certifications provided. The insurance carrier reduced payment citing fee guidelines.

   Per 28 TAC §134.240(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)."

   28 TAC §134.240(d)(3) states, in relevant part, "MMI evaluations will be reimbursed at $449 adjusted per §134.210(b)(4) and the designated doctor must apply the additional modifier 'W5.'" No adjustments found in 28 TAC §134.210(b)(4) apply for the date of service in question.

   28 TAC §134.240(d)(4) states, in relevant part, "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."

   28 TAC §134.240(d)(4)(A)(i)(II) states, "the reimbursement for the first musculoskeletal body area is $385 adjusted per §134.210(b)(4)." No adjustments found in 28 TAC §134.210(b)(4) apply for the date of service in question.

   The submitted documentation supports that Dr. Bronson performed an examination and placed the injured employee at maximum medical improvement, calculating impairment ratings. Per billing documents provided, these services were billed with procedure code 99456 and modifier "W5" for one unit.

   DWC finds that Dr. Bronson billed the examination in question in accordance with Per 28 TAC §134.240(d)(3) and (4). Therefore, the total reimbursable amount for this service is $834.00. Per submitted explanation of benefits dated August 13, 2024, the insurance carrier paid $449.00.

   28 TAC §134.250(4)(D) and (E) state,

   (D) When multiple IRs are required as a component of a designated doctor examination under this title, the designated doctor must bill for the number of body areas rated, and the insurance carrier must reimburse, $64 adjusted per §134.210(b)(4) for each additional IR calculation.

(E) When the division requires the designated doctor to complete multiple IR calculations, the designated doctor must apply the additional modifier "MI."

The submitted documentation supports that Dr. Bronson provided two additional impairment calculations, billing with procedure code 99456 and modifiers "W5" and "MI." No adjustments found in 28 TAC §134.210(b)(4) apply for the date of service in question. Therefore, the maximum allowable reimbursement for this service is $128.00. Per submitted explanation of benefits dated August 13, 2024, the insurance carrier paid this amount in full.

28 TAC §134.240(d)(5) states, in relevant part, "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.'" No adjustments found in 28 TAC §134.210(b)(4) apply for the date of service in question.

The submitted documentation supports that Dr. Bronson provided an opinion regarding the extent of the compensable injury, billing with procedure code 99456 with modifier "W6." Therefore, the total allowable reimbursement for this service is $642.00. Per submitted explanation of benefits dated August 13, 2024, the insurance carrier paid this amount in full.

DWC finds that Dr. Bronson is entitled to an additional reimbursement of $385.00. This amount 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 established that additional reimbursement of $385.00 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Insurance Company of the West must remit to Mark R. Bronson, D.C. $385.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 15, 2024 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 electronico CompConnection@tdi.texas.gov.