



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Joseph S. Coleman, D.C.

**Respondent Name**

Insurance Company of the West

**MFDR Tracking Number**

M4-25-0317-01

**Carrier's Austin Representative**

Box Number 04

**DWC Date Received**

October 7, 2024

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 23, 2024	Examination to Determine Maximum Medical Improvement and Impairment Rating – 99456	\$192.00	\$192.00

### Requestor's Position

"We'd billed the carrier \$834 for services and received only partial payment of \$642. We sent the carrier a request for reconsideration and the carrier has twice refused to pay the remaining balance of \$192."

**Amount in Dispute:** \$192.00

### Respondent's Position

"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 with no modifiers and 1 unit in the amount of \$834.00, the bill was reduced. To \$642.00 ...

"In review of the submitted billing the provider did not supply a modifier(s) to warrant an additional allowance. Allowance was made per the submitted billing in accordance with Rule §134.240."

## **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 §134.260](#) sets out the fee guidelines for examinations to determine maximum medical improvement performed by a doctor referred by the treating doctor.

### Denial Reasons

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

- G15 – (P12) Pricing is calculated based on the medical professional fee schedule value.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- Notes: "All submitted documentation regarding the attached claim has been re-evaluated. It is our opinion that the review is accurate; therefore, no [sic] additional allowance is recommended."

### Issues

1. Is Joseph S. Coleman, D.C. entitled to additional reimbursement for the examination in question?

### Findings

1. Dr. Coleman is seeking additional reimbursement for an examination to determine maximum medical improvement and impairment rating as referred by the treating doctor.

The documentation submitted supports that Dr. Coleman determined that the injured employee was at maximum medical improvement and performed an impairment rating evaluation of one musculoskeletal body area.

Per 28 TAC §134.260(b)(3), "If the referred doctor determines MMI has been reached and an IR evaluation is performed, the referred doctor must bill, and the insurance carrier must reimburse, both the MMI evaluation and the IR examination portions of the examination in accordance with subsection (c) of this section."

28 TAC §134.260(c) states, in relevant part,

- (c) The following applies for billing and reimbursement of an MMI or IR evaluation by a referred doctor.
  - (1) CPT code. The referred doctor must bill using CPT code 99456 with the appropriate modifier.
  - (2) MMI. MMI evaluations will be reimbursed at \$449 adjusted per §134.210(b)(4).
  - (3) IR. For IR examinations, the referred doctor must bill, and the insurance carrier must reimburse, the components of the IR evaluation. Indicate the number of body areas rated in the units column of the billing form.
    - (A) ...
      - (ii) For musculoskeletal body areas:
        - (l) the reimbursement for the first musculoskeletal body area is \$385 adjusted per §134.210(b)(4)

DWC finds that Dr. Coleman billed in accordance with 28 TAC §134.260. Therefore, the total allowable reimbursement for the services in question is \$834.00. Per explanation of benefits dated August 14, 2024, the insurance carrier paid \$642.00. An additional reimbursement of \$192.00 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 \$192.00 is due.

**Order**

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that Insurance Company of the West must remit to Joseph S. Coleman, D.C. \$192.00 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

January 24, 2025  
\_\_\_\_\_  
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](http://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](mailto: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](mailto:CompConnection@tdi.texas.gov).