



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Lorin Wolf, DC

Respondent Name

Employers Mutual Casualty Co

MFDR Tracking Number

M4-25-0777-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

December 5, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 6, 2024	99456 W5	\$385.00	\$385.00

Requestor's Position

"I have now received an EOB with a reduction in payment from \$834.00 down to \$449.00. According to TAC 28 §134.204 designator doctor fees are not permitted to be discounted.

Amount in Dispute: \$385.00

Respondent's Position

The Austin carrier representative for Employers Mutual Casualty Co is Flahive Ogden & Latson. The representative was notified of this medical fee dispute on December 10, 2024.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the 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 \(TAC\) §134.240](#) sets out the billing requirements and reimbursement guidelines for designated doctor examinations.
2. [28 TAC §133.10](#) sets out the required billing procedures forms/formats for healthcare provider billing.
3. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.

Denial Reasons

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

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- P12 – Workers' Compensation Jurisdictional Fee Schedule Adjustment.
- W3 – In accordance with TDI-DWC Rule 134.804. This bill has been identified as a request for reconsideration or appeal.

Issues

1. What services were included in the assigned designated doctor examination?
2. What rule is applicable to reimbursement?
3. Is the requester entitled to additional reimbursement?

Findings

The disputed service was rendered in August of 2024. The rule (28 TAC §134.240) applicable to designated doctor examinations was amended effective June 1, 2024. The service in question will be reviewed in accordance with the provisions of applicable rules and fee guidelines.

1. The requestor is seeking an additional payment of \$385 for date of service August 6, 2024. The insurance carrier reduced the payment of the claim based on the workers' compensation jurisdictional fee schedule.

Review of the submitted "Designated Doctor Evaluation and Report" indicates, "Purpose of Examination – Maximum Medical Improvement, - Impairment Rating."

Review of the Doctor Appointment Detail known to the Division found the DD Assignment ID of [redacted]. This assignment type was for the purpose of maximum medical improvement and impairment rating.”

DWC Rule 28 TAC 133.10 (f)(1)(N)(ii) states in pertinent parts, “All information submitted on required paper billing forms must be legible and completed in accordance with this section... The following date content or data elements are required for a complete professional or non-institutional medical bill related to Texas workers’ compensation health care. ...prior authorization number (CMS-1500/field 23) is required in the following situations: ...The division ordered a designated doctor examination and provided an assignment number. Included the assignment in the prior authorization filed (CMS-1500/field 23). Review of the submitted medical bill the requestor submitted the afore mentioned assignment number in the correct field.

Based on the DWC assigned designated doctor appointment type and the submitted medical report, the DWC finds the requestor is entitled to receive reimbursement for the designated doctor exam with maximum medical improvement and impairment rating.

2. DWC Rule 28 TAC §134.240 (d) states, “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).”

DWC Rule 28 TAC §134.240 (d)(3) states, “MMI evaluations will be reimbursed at \$449 adjusted per §134.210(b)(4), and the doctor must apply the additional modifier ‘W5’.”

DWC Rule 28 TAC §134.240 (d)(4) states, “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.

DWC Rule 28 TAC §134.240 (d)(4)(A)(ii) states, “For musculoskeletal body areas... the reimbursement for the first musculoskeletal body area is \$385.00 adjusted per §134.210(b)(4) ...”

Review of the submitted medical bill found the requestor billed with the appropriate CPT code and modifier for the DD examination with MMI and Impairment rating. The reimbursement amount for the DD exam with MMI is \$449.00. The reimbursement amount for the IR of one musculoskeletal body area is \$385.00. The total reimbursement is \$834.00.

3. As shown above the total Maximum Allowable Reimbursement for the disputed service is \$834.00. The insurance carrier paid \$449.00. An additional payment of \$385.00 is due to the request.

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 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 Employers Mutual Casualty Co must remit to Lorin Wolf, DC, \$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

March 20, 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. 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.