



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

James K. Baker, M.D.

Respondent Name

Zurich American Insurance Co.

MFDR Tracking Number

M4-25-0947-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

December 30, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 21, 2024	Examination to Determine Impairment Rating – 99455	\$201.84	\$0.00

Requestor's Position

"I am submitting an appeal for reconsideration of incorrectly reduced payment of impairment rating portion of MMI-IR for a patient that I was treating. The charge and correct reimbursement is 385.00 ... I was incorrectly paid 183.16 for the impairment rating, and you owe me \$201.84 additional payment for the impairment rating ... The new fee schedule has been in effect since June 1, 2024."

Amount in Dispute: \$201.84

Respondent's Position

The Austin carrier representative for Zurich American Insurance Co. is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on January 7, 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 \(TLC\) §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, effective June 1, 2024, 49 TexReg 1489](#), sets out the fee guidelines for maximum medical improvement and impairment examinations by referred doctors.

Denial Reasons

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

- 237 – The recommended allowance is based on usual, customary and reasonable rates for this geographical area.
- 309 – The charge for this procedure exceeds the fee schedule allowance.
- TXP12 – Workers' compensation jurisdictional fee schedule adjustment.
- TCP5 – Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement.

Issues

1. Is James K. Baker, M.D. entitled to additional reimbursement for the services in question?

Findings

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

The documents submitted to DWC indicate that Dr. Baker was a referred doctor acting in place of the treating doctor. The rule governing fees for exams of this type is 28 TAC §134.260, effective June 1, 2024, which 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.

Review of the bill included in this dispute request indicates that Dr. Baker billed for the services

in question using CPT code 99455. Therefore, no additional reimbursement can be 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 not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	March 20, 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 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.