



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Robert Jaehne, DC

Respondent Name

Employers Preferred Insurance Co

MFDR Tracking Number

M4-25-1221-01

Carrier's Austin Representative

Box Number 4

DWC Date Received

February 5, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 24, 2024	99456 W5 WP	\$100.00	\$100.00
Total		\$100.00	\$100.00

Requestor's Position

"Please accept the following Position Statement as required by Rule 133.307 (C)(2)(f).
...Designated doctor exam ...Carrier is required to pay designated doctor exams ...The current rules allow reimbursement ...An original bill and a reconsideration were submitted, the current rules allow reimbursement."

Amount in Dispute: \$100.00

Respondent's Position

The Austin carrier representative for Employers Preferred Insurance Co is Law Office of Ricky D Green. The representative was notified of this medical fee dispute on February 11, 2025.

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 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 §134.250](#) (adopted July 7, 2016, 41 TexReg 4839) sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.
3. [DWC Rule §134.210](#) sets out the medical fee guideline for workers' compensation specific services.

Adjustment Reasons

- 18 – Exact duplicate claim/service
- 247 – A payment or denial has already been recommended for this service

Issues

1. What service is in dispute?
2. What rules apply to the service in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor submitted a medical bill for date of service May 24, 2024 for a designated doctor exam, maximum medical improvement/impairment rating. The respondent Employers Preferred Insurance Company made a payment of \$700.00. Upon reconsideration, the requestor sought an additional \$100. The respondent did not submit a position statement or additional information in support of the reduction in payment.
2. This medical fee dispute involves an examination by a designated doctor for the purpose of establishing: if maximum medical improvement (MMI) has been reached; what date MMI was reached if applicable; and to provide impairment ratings (IR) if MMI has been reached.

On the disputed date of service, the requestor billed \$800 for CPT code 99456-W5-WP with two units of service. DWC Rule §134.250 (3)(C) states, "An examining doctor, other than the treating doctor, shall bill using CPT code 99456. Reimbursement shall be \$350."

DWC Rule §134.210 (e)(18)(20) states in pertinent parts, "Modifier W5 - designated doctor examination for impairment or attainment of MMI--This modifier shall be added to the

appropriate examination code performed by a designated doctor when determining impairment caused by the compensable injury and in attainment of MMI..

Modifier WP whole procedure - This modifier shall be added to the CPT code when both the professional and technical components of a procedure are performed by a single health care provider..

DWC finds that 28 TAC §134.250(adopted July 7, 2016, 41 TexReg 4839) (C) sets out the fee guidelines for maximum medical improvement examinations and impairment ratings and states in pertinent parts, For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.

(i) Musculoskeletal body areas are defined as follows:

- (I) spine and pelvis;
- (II) upper extremities and hands; and
- (III) lower extremities (including feet).

(ii) The MAR for musculoskeletal body areas shall be as follows:

- (I) \$150 for each body area if the diagnosis related estimates (DRE) method found in the AMA Guides fourth edition is used.
- (II) If full physical evaluation, with range of motion, is performed:
 - (-a-) \$300 for the first musculoskeletal body area; and
 - (-b-) \$150 for each additional musculoskeletal body area.

(iii) If the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s), the examining doctor shall bill using the appropriate MMI CPT code with modifier "WP." Reimbursement shall be 100 percent of the total MAR.

The submitted medical record supports that Dr. Jaehne, a designated doctor, performed an evaluation of maximum medical improvement (MMI) as ordered by DWC. Per 28 TAC §134.250 (3)(C), the maximum allowable reimbursement (MAR) for this examination is \$350.00.

A review of the submitted medical record finds that Dr. Jaehne performed an impairment rating (IR) evaluation of two musculoskeletal body areas, with range of motion. The rule at 28 TAC §134.250 (4)(C)(ii) defines the fees for the calculation of an impairment rating for musculoskeletal body areas. The MAR for the evaluation of the first musculoskeletal body area performed with range of motion is \$300.00. The MAR for the evaluation of subsequent musculoskeletal body areas is \$150.00 each. The requestor assigned an impairment rating utilizing range of motion for two musculoskeletal body areas. The total allowable reimbursement for the impairment rating of two musculoskeletal body areas with range of motion testing is \$450.00.

In accordance with 28 TAC §134.250, the reimbursements which apply to the disputed examination rendered on April 2, 2024, are:

- For an MMI examination, reimbursement is \$350.00.
- For an IR of the first musculoskeletal body area with range of motion, reimbursement is \$300.00.

- For an IR of a second musculoskeletal body area, reimbursement is \$150.00.
- DWC finds that the total maximum allowable reimbursement for the examination in question is \$800.00.
- The insurance carrier paid \$700.00 for line-item CPT code 99456-W5-WP two units.
- Additional reimbursement in the amount of \$100.00 is recommended.

3. DWC finds that additional reimbursement in the amount of \$100.00 is due for the services in dispute.

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 in the amount of \$100.00 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 Employers Preferred Insurance Co must remit to Robert Jaehne, DC \$100.00 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

April 29, 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.