



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Robert Elliott Canal, DC

Respondent Name

XL Insurance America Inc

MFDR Tracking Number

M4-25-1226-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

February 5, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 30, 2024	Designated Doctor Examination 99456-W6-RE	\$500.00	\$500.00
	Range of Motion Testing 95851	\$41.10	\$41.10
Total		\$541.10	\$541.10

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: \$541.10

Respondent's Position

The Austin carrier representative for XL Insurance America Inc is Flahive, Ogden & Latson. 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 [Texas Labor Code \(TLC\) §413.031](#) and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. [Texas Labor Code §408.0041](#) sets out provisions of designated doctor examinations.
2. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.
3. [28 TAC §134.203](#) sets out the fee guidelines for professional medical services.
4. [28 TAC §134.235](#) (adopted July 7, 2016, 41 TexReg 4839) sets out the fee guidelines for examinations to determine the extent of the compensable injury.
5. [28 TAC §134.240](#) (adopted July 7, 2016, 41 TexReg 4839) sets out the medical fee guideline for workers' compensation specific services.

Denial Reasons

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

- D53 – Extent of injury not finally adjudicated
- 18/224 – Exact duplicate claim/service.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- D00 – Based on further review, no additional allowance is warranted.

Issues

1. Is the insurance carrier's denial supported?
2. What rule is applicable to reimbursement?
3. Is the requester entitled to additional reimbursement?

Findings

1. Dr. Canal is seeking reimbursement for a designated doctor examination to determine the extent of a compensable injury with additional testing. The insurance carrier denied the charges stating final extent of injury not adjudicated. Texas Labor Code §408.0041(h)(1) states in pertinent part, "The insurance carrier shall pay for: an examination required under Subsection (a), (f), or (f-2)... Review of the information known to the Division found Dr. Canal conducted a division requested extent of injury exam on May 30, 2024 with code 99456, W6 RE. The insurance carrier's denial is not supported. The disputed services will be reviewed per applicable fee guideline.
2. The rules applicable to extent of injury exam are found at DWC Rule 28 TAC §134.240(C) which states, "Extent of the employee's compensable injury shall be billed and reimbursed in accordance with §134.235 of this title, with the use of the additional modifier "W6:

Additionally, DWC Rule 28 TAC §134.235 states, "When conducting a division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT code 99456 with modifier "RE." In either instance of whether maximum medical improvement/ impairment rating (MMI/IR) is performed or not, the reimbursement shall be \$500 in accordance with §134.240 of this title and shall include division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee."

The submitted medical bill contained code 99456 -W6, RE with a billed amount of \$500 for one unit. The reimbursement rate is \$500.00.

Dr. Canal also billed procedure code 95851 for one unit. This code is defined as "Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)." Documentation submitted to DWC supports that Dr. Canal performed range of motion testing for the right hip. Therefore, Dr. Canal is entitled to reimbursement for this service for one unit.

Reimbursement fee guidelines for professional services are addressed in DWC Rule 28 TAC §134.203(c), which states in relevant part: "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

- (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83...
- (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year ..."

To determine the MAR, the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) x Medicare Participating Amount.

- The DWC conversion factor for 2024 is 67.81.
- The Medicare conversion factor for 2024B is 33.2875.
- Per the submitted medical bills, the service was rendered in zip code 78516 which is in Medicare locality 0441299.

The Medicare participating amount for CPT code 95851 is \$20.74. The MAR is calculated as follows: $(67.81/33.2875) \times \$20.74 = \42.25 .

The total MAR for is \$42.25. Dr. Canal is seeking \$41.10 for this service. This amount is recommended.

3. As shown above, Dr. Robert Canal is entitled to reimbursement of \$500 for the extent of injury exam and \$41.10 for the range of motion testing. For a total reimbursement of \$541.10.

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 reimbursement of \$541.10 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 XL Insurance America Inc. must remit to Robert Elliott Canal, DC \$541.10 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 30, 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.