TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Kyle Jones, M.D.

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-25-1700-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
March 27, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 15, 2025	Examination by the Treating Doctor to Determine MMI – 99455-V5	$380.00	$0.00
	Examination by the Treating Doctor to Determine IR – 99455	$398.00	$0.00
	Total	$778.00	$0.00

Requestor's Position

"[Injured employee] was seen by his treating doctor, Kyle Jones, MD on 01/15/2025 for an MMI evaluation and impairment rating. Per the new billing guidelines by TDI-DWC, CPT code 99455-V5 was billed to the carrier for $380 for the MMI portion. CPT code 99455 was billed for the IR exam, using ROM for one musculoskeletal body area, for $398."

Amount in Dispute: $778.00

Respondent's Position

"On the submitted DWC-69 form, in box 13, Dr. Kyle Jones, MD indicated that he is the designated doctor selected by DWC to perform the MMI/IR exam. According to TAC rule 134.240(d), designated doctors should bill with CPT code 99456 with the correct modifier specified in subsections (d)(1-7). The medical bill for date of service 01/15/2025 was submitted

with CPT code 99455 which is reserved for for billing by the treating doctor in accordance with TAC rule 134.250(c).

"Our position is that no payment is due."

Response Submitted by: Texas Mutual Insurance Company

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) §130.1 sets out the requirements for examinations to determine maximum medical improvement and impairment rating.

2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

3. 28 TAC §134.250 sets out the fee guidelines for designated doctor examinations.

Denial Reasons

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

- CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment
- CAC-4 – The procedure code is inconsistent with the modifier used or a required modifier is missing
- 714 – Accurate license, CPT/HCPCS, NDC #, dates, units, days supply, modifiers are required. Submit corrections w/I 95 days from DOS.
- 732 – Accurate coding is essential for reimbursement modifier billed incorrectly or missing. Services are not reimbursable as billed.
- Note: "CLARIFICATION IS NEEDED IS THE DESIGNATED DR OR TREATING DR BILLING FOR MMI IR?"
- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 891 – No additional payment after reconsideration.

Issues

1. What are the relevant rules for this dispute?

2. Is the insurance carrier's denial of payment supported?

Findings

1. Kyle Jones, M.D. is seeking reimbursement for an examination to determine maximum medical improvement and impairment rating. DWC finds that the following rules apply to the disputed services. Emphasis is added as needed for clarity.

   28 TAC §130.1 states:

   (a) Authorized Doctor.
   (1) Only an authorized doctor may certify maximum medical improvement (MMI), determine whether there is permanent impairment, and assign an impairment rating if there is permanent impairment.
   (A) **Doctors serving in the following roles may be authorized** as provided in subsection (a)(1)(B) of this section.
   (i) **the treating doctor** (or a doctor to whom the treating doctor has referred the injured employee for evaluation of MMI and/or permanent whole body impairment in the place of the treating doctor, in which case the treating doctor is not authorized);
   (ii) a designated doctor; or
   (iii) a required medical examination (RME) doctor selected by the insurance carrier and approved by the division to evaluate MMI and/or permanent whole body impairment after a designated doctor has performed such an evaluation …
   (d) Reporting.
   (1) Certification of MMI, determination of permanent impairment, and assignment of an impairment rating (if permanent impairment exists) for the current compensable injury **requires completion, signing, and submission of the Report of Medical Evaluation** and a narrative report.
   (A) The Report of Medical Evaluation **must be signed by the certifying doctor**. The certifying doctor may use a rubber stamp signature or an electronic facsimile signature of the certifying doctor's personal signature.

   28 TAC §134.250 states:

   (a) The total maximum allowable reimbursement (MAR) for a maximum medical improvement (MMI) or impairment rating (IR) examination is equal to the MMI evaluation reimbursement plus the reimbursement for the body area or areas evaluated for the assignment of an IR. **The MMI or IR examination must include:**
   (1) the examination;
   (2) consultation with the injured employee;
   (3) review of the records and films;
   (4) **the preparation and submission of reports** (including the narrative report and responding to the need for further clarification, explanation, or reconsideration), calculation tables, figures, and worksheets; and
   (5) tests used to assign the IR, as outlined in the AMA Guides to the Evaluation of Permanent Impairment (AMA Guides), as stated in the Labor Code and Chapter 130 of this title.

(b) **Treating doctors must only bill and be reimbursed for an MMI and IR examination if they are an authorized doctor** in accordance with the Labor Code and Chapter 130 and §180.23 of this title.
(c) The following applies for billing and reimbursement of an MMI or IR evaluation **by a treating doctor**.
(1) CPT code. The treating doctor must bill using CPT code **99455** with the appropriate modifier. Modifiers "V3," "V4," or "V5" must be added to CPT code 99455 to correspond with the last digit of the applicable office visit.
(2) MMI. MMI evaluations must be reimbursed based on the applicable established patient office visit level associated with the examination under §134.203 of this chapter.
(3) IR. For IR examinations, the treating 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.

2. Reimbursement for examinations to determine maximum medical improvement and impairment rating is dependent upon the requirements found in 28 TAC §134.250(a), including subsection (4), "the preparation and submission of reports." The completion of the Report of Medical Evaluation as required by 28 TAC §130.1(d)(1) includes, in relevant part,

- Box 13, which requires doctors to indicate the role they are serving in to support authorization in accordance with 28 TAC §130.1(a), and
- Box 18, which includes the signature of the certifying doctor in accordance with 28 TAC §130.1(d).

In his position statement, Dr. Jones indicated that his role was as the treating doctor and the examination was billed using CPT code 99455. However, in Box 13 of the Report of Medical Evaluation, Dr. Jones indicated that his role was as a designated doctor. Dr. Jones also failed to complete Box 18 of the report.

DWC finds that the report filed for the examination in question was not consistent with the submitting billing. Therefore, the insurance carrier's denial of payment was supported. No 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 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

		April 30, 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 electronico CompConnection@tdi.texas.gov.