TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

General Information

Requester Name
Edward W. Smith, D.O.

Respondent Name
National Liability and Fire Insurance Co.

MFDR Tracking Number
M4-25-3031-01

Carrier's Austin Representative
Box Number 6

DWC Date Received
July 23, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 2, 2025	Designated Doctor Examination 99456-W5-NM-25	$311.00	$311.00

Requester's Position

"Carrier partially reimbursed DD for services and improperly declined to pay for all services requested, ordered, and provided according to DWC Rules 28 TAC Chapter 134… All submitted charges and coding conform to DWC Rules 28 TAC Chapter 134. The original claim form was properly coded and submitted in a timely fashion to the carrier."

Amount in Dispute: $311.00

Respondent's Position

The Austin carrier representative for National Liability and Fire Insurance Co. is Stone Loughlin & Swanson LLP. The representative was notified of this medical fee dispute on July 25, 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 §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 §134.240 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.
3. 28 TAC §127.130 sets out qualification standards for Designated Doctor examinations.
4. 28 TAC §134.210 sets out the medical fee guideline for Workers' Compensation specific services.

Denial Reasons

- 95 - PLAN PROCEDURES NOT FOLLOWED.
- G15 - PRICING IS CALCULATED BASED ON THE MEDICAL PROFESSIONAL FEE SCHEDULE VALUE.
- P12 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- U00 - THERE WAS NO UR PROCEDURE/TREATMENT REQUEST RECEIVED.
- W3 & 350 - IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

1. What rules apply to the service in dispute?
2. According to the submitted documentation, what designated doctor services were provided on the date in dispute?
3. Is the requester entitled to additional reimbursement?

Findings

1. 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 requester billed a total amount of $776.00 for designated doctor services billed under CPT codes 99456-W5-NM-25. CPT code 99456 indicates the service of a maximum medical improvement (MMI) and/or impairment rating (IR) examination by a designated doctor.

DWC finds that 28 TAC §134.240, adopted to be effective June 1, 2024, applies to the reimbursement of the services in dispute. 28 TAC §134.240(d) states, in pertinent part:

"(2) (A) If the designated doctor determines that MMI has not been reached, the MMI evaluation portion of the examination must be billed and reimbursed in accordance with subsection (d) of this section. The designated doctor must add modifier 'NM'…

(C) If the designated doctor determines MMI has been reached and an IR evaluation is performed, both the MMI evaluation and the IR evaluation portions of the examination must be billed and reimbursed in accordance with subsection (d) of this section.

(3) MMI. MMI evaluations will be reimbursed at $449 adjusted per §134.210(b)(4), and the designated doctor must apply the additional modifier 'W5.'

(4) IR. 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.

(A) For musculoskeletal body areas, the designated doctor may bill for a maximum of three body areas.

(i) Musculoskeletal body areas are:
(I) spine and pelvis: (musculoskeletal structures of torso)
(II) upper extremities and hands; and
(III) lower extremities (including feet).

(ii) For musculoskeletal body areas:
(I) the reimbursement for the first musculoskeletal body area is $385 adjusted per §134.210(b)(4); and
(II) the reimbursement for each additional musculoskeletal body area is $192 adjusted per §134.210(b)(4).

(B) For non-musculoskeletal body areas, the designated doctor must bill, and the insurance carrier must reimburse, for each non-musculoskeletal body area examined.

(i) Non-musculoskeletal body areas are defined as follows:
(I) body systems;
(II) body structures (including skin); and
(III) mental and behavioral disorders.

(ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides.

(iii) The reimbursement for the assignment of an IR in a non-musculoskeletal body area is $192 adjusted per §134.210(b)(4)."

28 TAC §134.240 (g), which applies to the services in this dispute, states, "When the division orders the designated doctor to perform an examination of an injured employee with one or more of the diagnoses listed in §127.130(b)(9)(B) - (I) of this title:

(1) The designated doctor must add modifier '25' to the appropriate examination code.

(2) The designated doctor must add modifier '25' once per bill when addressing issues on

the same day, regardless of the number of diagnoses or the number of issues the division ordered the designated doctor to examine.

(3) The designated doctor must bill, and the insurance carrier must reimburse, $300 adjusted per §134.210(b)(4) in addition to the examination fee."

DWC finds that 28 TAC §134.210 applies to the annual fee adjustment of the disputed services, stating in pertinent part, "(b)(4) Fees established in §§134.235, 134.240, 134.250, and 134.260 of this title will be:

"(A) adjusted once by applying the Medicare Economic Index (MEI) percentage adjustment factor for the period 2009 - 2024.

(B) adjusted annually by applying the MEI percentage adjustment factor identified in §134.203(c)(2).

(C) rounded to whole dollars by dropping amounts under 50 cents and increasing amounts from 50 to 99 cents to the next dollar. For example, $1.39 becomes $1 and $2.50 becomes $3.

(D) effective on January 1 of each new calendar year."

2. A review of the submitted documents finds that on the disputed date of service, the medical record supports that the requester, a designated doctor, performed an evaluation of maximum medical improvement (MMI) as ordered by DWC. Per 28 TAC §134.240(d), the maximum allowable reimbursement (MAR) in 2025 for this examination is $465.00.

   A review of the submitted medical record additionally finds that the injured employee was not found to be at MMI; therefore, the designated doctor was not able to perform an impairment rating (IR). The requester appended procedure code 99456 with the modifier "NM" in accordance with 28 TAC §134.240.

   The medical record submitted supports that the designated doctor examination performed on the disputed date of service involved a complex diagnosis as listed in 28 TAC §127.130(b)(9)(B)-(I). The rule at 28 TAC §134.240(g), which addresses the billing and reimbursement of examinations involving certain diagnoses, states, "When the division orders the designated doctor to perform an examination of an injured employee with one or more of the diagnoses listed in §127.130(b)(9)(B) - (I) of this title:

   (1) The designated doctor must add modifier "25" to the appropriate examination code.

   (2) The designated doctor must add modifier "25" once per bill when addressing issues on the same day, regardless of the number of diagnoses or the number of issues the division ordered the designated doctor to examine.

   (3) The designated doctor must bill, and the insurance carrier must reimburse, $300 adjusted per §134.210(b)(4) in addition to the examination fee."

   The MAR for this examination by an appropriately board-certified physician involving a diagnosis listed in 28 TAC §127.130(b)(9)(B)-(I) in 2025 is $311.00.

3. The requester, Edward W. Smith, D.O., is seeking additional reimbursement in the amount of $311.00 for a designated doctor examination rendered on June 2, 2025.

   DWC finds that in accordance with 28 TAC §134.240, the appropriate total amount of reimbursement for the disputed designated doctor examination rendered on June 2, 2025, is $776.00. The insurance carrier reimbursed the disputed services a total amount of $465.00.

   DWC finds that the requester is entitled to additional reimbursement in the amount of $311.00.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requester and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has established that additional reimbursement is due in the amount of $311.00.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to additional reimbursement for the disputed services. It is ordered that National Liability and Fire Insurance Co. must remit to Edward W. Smith, D.O., $311.00 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	September 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 3 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 3 o correo electronico CompConnection@tdi.texas.gov.