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

General Information

Requester Name
Marcus Hayes, D.C.

Respondent Name
XL Specialty Insurance Co.

MFDR Tracking Number
M4-25-3386-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
August 26, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 12, 2025	Examination to Determine MMI and IR by Treating Doctor – 99455-V4	$981.45	$981.45

Requester's Position

"In this particular case, the DWC MFG for 2025 determines that the 'V4' value is $278.17, the IR value for the first musculoskeletal body area (lumbar spine) is $398.00 and the IR value for the second body area (right hip, right knee and right ankle) is $199.00 and the IR value for the third body area (right shoulder) is $199.00. Therefore, the correct reimbursement should've been $1,074.17. CRS has reimbursed AI&FATC $92.72. Therefore, AI&FATC requests CRS to reconsider and remit the balance due of $981.45 for the MMI certification and Impairment Rating determination for the 3 body areas."

Amount in Dispute: $981.45

Respondent's Position

The Austin carrier representative for XL Specialty Insurance Co. is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on August 27, 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 §134.203 sets out the fee guidelines for professional medical services.

3. 28 TAC §134.210 sets out the fee guidelines for workers' compensation specific services.

4. 28 TAC §134.250 sets out the fee guidelines for maximum medical improvement and impairment examinations by treating doctors.

Denial Reasons

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

- 01 – The charge for the procedure exceeds the amount indicated in the fee schedule.
- 151 – Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- UY – The number of units billed for this procedure code exceeds the reasonable number usually provided in a given setting, as defined within the Medically Unlikely Edits (MUEs) which is published and maintained by the Centers for Medicare and Medicaid Services. The provider's charge was granted an allowance up to the MUE value.

Issues

1. Is the insurance carrier's reduction of payment based on MUE provisions supported?

2. Is Marcus Hayes, D.C. entitled to additional reimbursement for the examination in question?

Findings

1. Dr. Hayes is seeking additional reimbursement for an examination to determine maximum medical improvement and impairment rating performed on June 12, 2025. The insurance carrier denied payment based, in part, stating, "The number of units billed for this procedure code exceeds the reasonable number usually provided in a given setting, as defined within the Medically Unlikely Edits (MUEs) …"

   28 TAC §134.210(a) states, in relevant part, "Specific provisions contained in the Labor Code or division rules, including this chapter, take precedence over any conflicting provision adopted or used by the Centers for Medicare and Medicaid Services (CMS) in administering the Medicare program."

   28 TAC §134.210(e) states, "For services provided under §§134.235, 134.240, 134.250, or 134.260, health care providers must bill and be reimbursed the MAR."

   Because the services in question are provided under 28 TAC §134.250, Medicare provisions do not apply for reimbursement. Therefore, the insurance carrier's reduction for this reason is not supported.

2. Because the insurance carrier's reduction of payment based on MUE provisions is not supported, DWC will review payment for the services in question based on applicable fee guidelines.

   Dr. Hayes billed this service in the role of the treating doctor. 28 TAC §134.250(c) states, "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.

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

   (i) Musculoskeletal body areas are:

   (I) spine and pelvis;

   (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).

Dr. Hayes billed the examination using procedure code 99455 with modifier V4; therefore, maximum allowable reimbursement (MAR) corresponds to established office visit 99214, reimbursed in accordance with 28 TAC §134.203.

28 TAC §134.203(c) 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 2025 is 70.18.
- The Medicare conversion factor for 2025 is 32.3465.
- Per the submitted medical bills, the service was rendered in zip code 77074 which is in Medicare locality 0441218.
- The Medicare participating amount for CPT code 99214 is $128.21.

The MAR is calculated as follows: (70.18/32.3465) x $128.21 = $278.17.

Dr. Hayes also provided impairment ratings for three musculoskeletal body areas. Therefore, reimbursement for this portion of the examination is $796.00.

The total allowable amount for the services in question is $1,074.17. Per explanation of benefits dated July 15, 2025, the insurance carrier paid $92.72. An additional reimbursement of $981.45 is recommended.

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 of $981.45 is due.

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 XL Specialty Insurance Co. must remit to Marcus Hayes, D.C. $981.45 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	November 20, 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 electronico CompConnection@tdi.texas.gov.