



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requester Name**

Kyle E. Jones, M.D.

**Respondent Name**

Texas Mutual Insurance Co.

**MFDR Tracking Number**

M4-26-0275-01

**Carrier's Austin Representative**

Box Number 54

**DWC Date Received**

September 27, 2025

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 15, 2025	Examination to Determine Impairment Rating - 99455	\$199.00	\$0.00

### Requester's Position

"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. Payment was received for the MMI portion but only \$199 was paid for the impairment rating."

**Amount in Dispute:** \$199.00

### Respondent's Position

"Review of documentation submitted by KYLE JONES MD there is not sufficient evidence to prove an additional body area. The impairment rating was given for ... which is a non-musculoskeletal area and was reimbursed at \$199.00."

**Response Submitted by:** Texas Mutual Insurance Co.

## 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 [§134.260](#) sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating by a treating doctor.

### Denial Reasons

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

- CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
- G15 – Pricing is calculated based on the medical professional fee schedule value.
- 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. Is Kyle E. Jones, M.D. entitled to additional reimbursement for the examination in question?

### Findings

1. Dr. Jones is seeking additional reimbursement for an examination to determine maximum medical impairment and impairment rating. Dr. Jones argued that "CPT code 99455 was billed for the IR exam, using ROM for one musculoskeletal body area, for \$398."

DWC reviewed the medical documentation submitted with this dispute and finds that the only body area reviewed for impairment was a non-musculoskeletal body area. 28 TAC §134.260(c)(3)(B)(iii) states, " The reimbursement for the assignment of an IR in a non-musculoskeletal body area is \$192 adjusted per §134.210(b)(4)."

The total adjusted reimbursement for one musculoskeletal body area is \$199.00. Per explanation of benefits dated May 8, 2025, the insurance carrier reimbursed this amount in full. No additional reimbursement 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 not established that additional reimbursement is due.

## Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to \$0.00 reimbursement for the disputed services.

### Authorized Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
January 8, 2026

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](http://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](mailto: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](mailto:CompConnection@tdi.texas.gov).