



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

LES BENSON

Respondent Name

SERVICE LLOYDS INSURANCE CO

MFDR Tracking Number

M4-11-1251-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

December 14, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "THE DOS(S) 8/17/10 WAS NOT PAID APPROPRIATELY:

"NOT ALL INFO NEEDED FOR ADJUDICATION WAS SUPPLIED"

"ADDITIONAL INFORMATION NEEDED TO REVIEW CHARGES."

Amount in Dispute: \$500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent maintains its position that the return to work evaluation billed for by the Requestor was not actually performed. Since no RTW evaluation was performed, no reimbursement can be made to the Requestor."

Response Submitted by: Harris & Harris

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 17, 2010	CPT Code 99456-W8-RE	\$500.00	\$ 0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.204 sets out the fee guideline for workers' compensation specific services on or after March 1, 2008.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 105 – Additional information needed to review charges
 - 16 – Not all info needed for adjudication was supplied
 - RE – Return to work and/or evaluation of medical care
 - W8 – Designated Doctor Examination for return to work

Issues

- 1. Is CPT Code 99456-W8-RE supported?
- 2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Labor Code §134.204 (i)(1)(E) states: “(E) Ability of the employee to return to work shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier "W8"; and...”

28 Texas Labor Code §134.204 (k) states: “(k) The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. 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 MMI/IR is performed or not, the reimbursement shall be \$500 in accordance with subsection (i) of this section 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.”

Review of the submitted documentation provided does not support that a Return to Work Examination was performed for date of service August 17, 2010.

2. The respondent issued payment in the amount of \$0.00. Based upon the documentation submitted, no additional reimbursement is recommended

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	5/16/14 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.