



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

J. THOMAS DILGER JR, MD

Respondent Name

AMERICAN ZURICH INSURANCE CO

MFDR Tracking Number

M4-13-1100-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

JANUARY 3, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This is a Designated Doctor Examination performed on 3/29/12."

Amount in Dispute: \$500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Respondent submitted a copy of statement that indicates payment of \$500.00 was issued for the disputed date of service on January 8, 2013.

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 29, 2012	CPT Code 99456-RE-W8 Designated Doctor Examination for Return to Work	\$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, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
- Neither party to this dispute submitted copies of the explanation of benefits to support denial/reduction of payment for the disputed services.

Issues

- Did the Designated Doctor bill for the Return to Work evaluations in accordance with medical fee guideline?
- Is the requestor entitled to reimbursement?

Findings

- On the disputed date of service the requestor billed CPT code 99456-RE-W8.

- 28 Texas Administrative Code §134.204(i)(1)(E) states “The following shall apply to Designated Doctor Examinations. (1) Designated Doctors shall perform examinations in accordance with Labor Code §§408.004, 408.0041 and 408.151 and Division rules, and shall be billed and reimbursed as follows: (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’.”
- 28 Texas Administrative Code §134.204(n)(23) defines the “W8” modifier as “Designated Doctor Examination for Return to Work--This modifier shall be added to the appropriate examination code performed by a designated doctor when determining the ability of employee to return to work.”

A review of the submitted medical billing finds that the requestor billed modifier “W8” for the return to work examination. The Division concludes that the requestor billed for the testing in accordance with 28 Texas Administrative Code §134.204.

2. The maximum allowable reimbursement (MAR) for CPT code 99456-RE-W8 is:

- 28 Texas Administrative Code §134.204(k) states “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 fee.”

The requestor billed CPT code 99456-RE-W8 for the return to work evaluation per 28 Texas Administrative Code §134.204(k).

The Division finds that the total allowable for the return to work evaluations is \$500.00. The respondent paid \$500.00. As a result, the requestor is not entitled to reimbursement of \$0.00.

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

		12/19/2014
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 in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request 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 §141.1(d).

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