



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

STEPHEN RINGEL

Respondent Name

NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number

M4-13-2345-01

Carrier's Austin Representative Box

Box Number 19

MFDR Date Received

May 14, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "A claim for the above RME was faxed to Chartis Insurance Adjuster Scott Cordell on 3/18/13. To this date, we have not received payment."

Amount in Dispute: \$1,000.00

RESPONDENT'S POSITION SUMMARY

Respondent's Summary: Carrier acknowledged DWC-60, no response submitted.

Response Submitted by: New Hampshire Insurance Company.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 5, 2013	CPT Code 99456 RE	\$1,000.00	\$500.00

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 a medical fee dispute.
- 28 Texas Administrative Code §134.204 sets out the fee guideline for workers' compensation specific services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:

No explanation of benefits provided

Issues

- Did the requestor perform a division ordered exam?
- Is the requestor entitled to reimbursement?

Findings

- Review of the documentation submitted finds a "Commissioner Order" approving request to perform a Required Medical Exam (RME) for the purpose of maximum medical improvement, impairment rating and extent of injury. Therefore, the requestor did perform a division ordered exam.

2. 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..."

Review of the documentation submitted finds that the requestor billed one unit for CPT code 99456 RE. The division finds that the requestor is entitled to reimbursement. Reimbursement in the amount of \$500.00 is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$500.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	June 9, 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.