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
GENEVA MEDICAL MANAGEMENT

Respondent Name
OLD REPUBLIC GENERAL INSURANCE

MFDR Tracking Number
M4-13-2635-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
June 17, 2103

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Dr. Anderson requests Medical Dispute Resolution in pursuant of Rule 133.305 Medical Dispute Resolution in the above referenced patients case. **RMEs and Evaluation of Medical Care (EMC) Exams**

When conducting Division or insurance carrier requested RTW/EMC examination, the following billing and reimbursement guidelines apply:

- The examining doctor bills and is reimbursed using the "work related or medical disability examination by other than the treating physician. . . " CPT Code 99456 with the "RE" modifier.
- Required testing is billed using the appropriate CPT codes and is reimbursed in addition to the examination."

Amount in Dispute: $175.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please find our initial response to the attached MDR. We have escalated the bill for additional review and it remains in process at this time. We will submit a supplemental response upon completion of the pending review. The carrier will contact the provider to discuss resolution and withdrawal of the MDR once the bill processing has been finalized."

Response Submitted by: Gallagher Bassett Services, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 11, 2012	CPT Code 99456-RE	$175.00	$175.00

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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.204 sets out the fee guideline for workers' compensation specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
    - 59 – Processed based on multiple or concurrent procedure rules

Issues

1. Is the requestor entitled to reimbursement for disputed service code 99456-RE?

Findings

1. Per 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."

   Review of the submitted documentation provided finds disputed procedure code 99456-RE is supported. Requestor billed with CPT Code 99456-RE with one unit in the amount of $500.00. The total MAR for CPT Code 99456-RE is $500.00. Carrier reimbursed the requestor $325.00 leaving a balance of $175.00 due.

   Therefore, the requestor is entitled to additional reimbursement in the amount of $175.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $175.00.

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 $175.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		9/26/14
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.