**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**
KUNJEELAL CHANDRAKAR

**Respondent Name**
OLD REPUBLIC GENERAL INSURANCE

**MFDR Tracking Number**
M4-14-0169-01

**Carrier's Austin Representative Box**
Box Number 44

**MFDR Date Received**
September 18, 2013

## REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** RE exams pays as follows & are not secondary to an MMI/IR exam first exam=$500.00 second exam=$250.00 subsequent exams=$125.00 $325 &$162.50 do not appear in the fee schedule **Please read the rules & stop allowing these amounts for an RE exam**.""

**Amount in Dispute:** $262.50

## RESPONDENT'S POSITION SUMMARY

**Respondent's Summary:** "Multiple examinations under the same specific Division order are performed concurrently (other than MMI/IR) as outlined in §134.204(i): 1st=100% of fee 2cd=50% subsequent=25% of fee."

**Submitted by:** Gallagher Bassett Services, Inc.

## SUMMARY OF FINDINGS

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| March 25, 2013 | CPT Code 99456 RE W8, 99456 RE W7 | $262.50 | $262.50 |

## 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 a medical fee dispute.
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:

   Explanation of benefits

   - *16- (16) Claim/service lacks information which is needed for adjudication.
   - *59 (59) Processed based on multiple or concurrent procedure rules.

**Issues**

1. Did the insurance carrier pay correct reimbursement amount to the provider?
2. Is the requestor entitled to reimbursement?

## Findings

1. In its position statement, the carrier states in pertinent "Multiple examinations under the same specific Division order are performed concurrently (other than MMI/IR) as outlined in §134.204(i): 1st=100% of fee 2cd=50% subsequent=25% of fee. "

- 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…"
- 28 Texas Administrative Code §134.204 (2) (A) states "When multiple examinations under the same specific Division order are performed concurrently under paragraph (1)(C) - (F) of this subsection: (A)the first examination shall be reimbursed at 100 percent of the set fee outlined in subsection (k) of this section; (B)the second examination shall be reimbursed at 50 percent of the set fee outlined in subsection (k) of this section; and (C)subsequent examinations shall be reimbursed at 25 percent of the set fee outlined in subsection (k) of this section.
- 28 Texas Administrative Code §134.204 (1)( C) –(F) of this subsection states "(C) Extent of the employee's compensable injury shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier "W6;" (D)Whether the injured employee's disability is a direct result of the work-related injury shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier "W7;" (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 (F)Issues similar to those described in subparagraphs (A) - (E) of this paragraph shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier "W9."

Review of the documentation found that the requestor billed CPT code 99456 RE W8 and 99456 RE W7 for date of service 3/25/13. Per rule §134.204 (2) (A) the first examination shall be reimbursed at 100 percent. (C) subsequent exams shall be reimbursed at 25 percent…

1. The respondent issued payment in the amount of $487.50. Based upon the documentation submitted, additional reimbursement in the amount of $262.50 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 $262.50 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

| | | |
|---|---|---|
| | | April 1, 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**.