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
DR. MATTHEW HIGGS

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-14-0968-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
NOVEMBER 25, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We seek full reimbursement for the outstanding balance of $250.00 along with interest accrued according to Rule 134.803."

Amount in Dispute: $250.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 10, 2013	CPT Code 99456-W6-RE	$250.00	$250.00

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, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
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.
   - BL-This bill is a reconsideration of a previously reviewed bill. Allowance amounts do not reflect previous payments.

The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on December 3, 2013. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not

submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Issues

1. Did the Designated Doctor bill for the Extent of Injury evaluations in accordance with medical fee guideline?
2. Is the requestor entitled to reimbursement?

Findings

1. On the disputed date of service the requestor billed CPT codes 99456-W6-RE.

    - 28 Texas Administrative Code §134.204(i)(1)(A) 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: (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;' and (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)(21) defines the "W6" modifier as "Designated Doctor Examination for Extent--This modifier shall be added to the appropriate examination code performed by a designated doctor when determining extent of the employee's compensable injury."

    A review of the submitted medical billing finds that the requestor billed modifiers "W6" for the extent of injury 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 codes 99456-RE-W6 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 Division finds that the total allowable for the extent of injury and return to work evaluations is $500.00. The respondent paid $250.00. As a result, the requestor is entitled to reimbursement of $250.00.

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 $250.00.

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 $250.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		10/08/2014
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.