



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

FRANCIS BURCH MD

Respondent Name

CITY OF SAN ANTONIO

MFDR Tracking Number

M4-14-2501-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

April 11, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "99456 RE SECON EXAM PER ORDER PAYS \$250.00 & IS NOT INCLUDED WITH ANY OTHER SERVICE/PROCEDURE."

Amount in Dispute: \$250.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The issue is in regards to the reimbursement for return to work evaluation billed under procedure code 99456W8RE. Page one of the medical records from Dr. Burch state: "I was asked to determine his impairment rating, maximum medical improvement date and extent of injury." He makes no mention of being requested to address return to work ... An allowance of \$350.00 was previously recommended for code 99456W5NM and \$500.00 for code 99456W6RE. However, since the injured employee was already working and Dr. Burch did not provide any new information, no allowance is recommended for 99456W8RE."

Response Submitted by: Argus

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 02, 2013	CPT Code 99456-W8-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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 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:
 - W3W – NO REIMBURSEMENT RECOMMENDED ON RECONSIDERATION. PREVIOUS RECOMMENDATION WAS IN ACCORDANCE WITH THE WORKERS' COMPENSATION STATE FEE SCHEDULE
 - 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the total allowable amount for the return to work examination?
3. Is the requestor entitled to reimbursement?

Findings

1. The dispute involves a Designated Doctor Return to Work (RTW) Examination, with reimbursement subject to the provisions of 28 Texas Administrative Code §134.204 (i)(2) and (k), which 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 and (k) 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.”
2. In order for the requestor to be reimbursed pursuant to rule §134.204(i)(2), the requestor was required to performed extent of injury and return to work examinations under the same division order. Review of the submitted documentation finds the requestor performed extent of injury and return to work examination under the same division order. The Division concludes that the return to work examination is allowed at \$250.00 in accordance with 28 Texas Administrative Code §134.204(i)(2)(B) and (k).
3. The division concludes that the total allowable for the return to work examination is \$250.00. The respondent issued payment in the amount of \$0.00 for the return to work examination. Based upon the documentation submitted, additional reimbursement in the amount of \$250.00 is recommended.

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

Signature	Medical Fee Dispute Resolution Officer	11/20/14 Date
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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.