TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Charles Kennedy, M.D.

Respondent Name
City of San Antonio

MFDR Tracking Number
M4-15-3556-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 25, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Requesting your assistance in getting the insurance company to pay for services rendered."

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "TAC §134.204(k) states: In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500.00.

Therefore, the previous reimbursement of $500.00 is correct and no additional allowance is due."

Response Submitted by: Argus Services Corporation

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 9, 2014	Required Medical Examination (99456-RE-WP)	$300.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 guidelines for billing and reimbursing Division-specific services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12A – Workers Compensation jurisdictional fee schedule adjustment.
   - W3W – No reimbursement recommended on reconsideration. Previous recommendation was in accordance with Workers' Compensation State Fee Schedule.

Issues

1. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor lists the services in dispute on the Medical Fee Dispute Resolution Request (DWC060) as CPT Code 99456-RE-WP. This is consistent with the billing codes on the CMS-1500 submitted with the dispute. 28 Texas Administrative Code §134.204 (n) states, in relevant part, "(7) RE, Return to Work (RTW) and/or Evaluation of Medical Care (EMC)--This modifier shall be added to CPT Code 99456 when a RTW or EMC examination is performed … (18) WP, Whole Procedure--This modifier shall be added to the CPT code when both the professional and technical components of a procedure are performed by a single HCP. "

   The fee for RTW/EMC evaluations is addressed in 28 Texas Administrative Code §134.204 (k), which 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 requestor submitted a bill for a RTW/EMC evaluation; therefore, the MAR for this service is $500.00

2. The total MAR for the disputed charge is $500.00. The insurance carrier paid $500.00. Therefore, no further reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Laurie Garnes	July 24, 2015
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, 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 MFDR 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.