



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

Lisa Wheeler, D.C.

Respondent Name

Service Lloyds Insurance Company

MFDR Tracking Number

M4-16-0162-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

September 18, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "... this is a bill for an Impairment Rating examination as referred by the claimant's treating doctor.

We billed a total of \$1,750.00 for the services provided. *We have received no payment from your company.*

Please issue a payment of \$1,750.00 to settle this claim.

Amount in Dispute: \$650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CorVel maintains, the requestor Landmark Exams is entitled to **\$0.00** reimbursement for the medical disability examination performed on 07/06/15 to address Impairment (IR) based on failure to appropriately submit medical billing in accordance with workers' compensation specific services outlined under 28 TAC Chapter 134..."

Modifier RE is not appropriate for this exam by this provider. RE modifier is for RTW or Evaluation of Medical Care Exam and is for Designated Doctor or RME Doctor use."

Response Submitted by: CorVel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 6, 2015	Referral Doctor Examination to determine MMI/IR	\$650.00	\$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 fee guidelines for Division-specific services.
- 3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 4 – Required Modifier Missing or Inconsistent with procedure
 - Notes: “MODIFIER RE IS NOT APPROPRIATE FOR THIS EXAM BY THIS PROVIDER”

Issues

Are the insurance carrier’s reasons for denial of payment supported?

Findings

The insurance carrier denied disputed services with claim adjustment reason code 4 – “Required Modifier Missing or Inconsistent w/proc,” and stating, “MODIFIER RE IS NOT APPROPRIATE FOR THIS EXAM BY THIS PROVIDER.” The services in question include procedure code 99456 with modifiers RE and WP. 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.’

Review of the submitted information finds that the examination in dispute was not requested by the Division or the insurance carrier. Further, the narrative and requestor’s position statement indicate that the examination in dispute is for an examination to determine if the injured employee had reached maximum medical improvement, and if so, determine the impairment rating. These examinations are addressed in 28 Texas Administrative Code §134.204 (j). The insurance carrier’s denial reason is supported. Additional reimbursement cannot be 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

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	November 6, 2015 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, 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.