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
EARL HENDRIKZ, DC

Respondent Name
STANDARD FIRE INSURANCE CO

MFDR Tracking Number
M4-18-0987-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
DECEMBER 7, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER IS REQUIRED TO PAY DESIGNATED DOCTOR EXAMS."

Amount in Dispute: $850.00

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
August 9, 2017	CPT Code 99456-W5-NM Designated Doctor Evaluation Maximum Medical Examination and Impairment Rating (MMI/IR)	$350.00	$350.00
	CPT Code 99456-W8-RE Return to Work Evaluation	$500.00	$500.00
TOTAL		$850.00	$850.00

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 §134.235, effective July 7, 2016, sets the reimbursement guidelines for return to work evaluations.
3. 28 Texas Administrative Code §134.240, effective July 7, 2016, sets the reimbursement guidelines for Designated Doctor Examinations.
4. 28 Texas Administrative Code §134.250, effective July 7, 2016, sets the reimbursement guidelines for

Maximum Medical Improvement Evaluations and Impairment Rating Examinations.

5. Neither party to this dispute submitted any explanation of benefits for the disputed services to support the issue in dispute.

Issues

1. What is the applicable fee guideline for the disputed issue?
2. Is the requestor entitled to reimbursement for 99456-W5-NM?
3. Is the requestor entitled to reimbursement for 99456-W8-RE?

Findings

1. The applicable fee guideline and statute for the disputed services is found in 28 Texas Administrative Code §134.240, §134.250 and §134.235.

2. On the disputed date of service, the requestor billed CPT codes 99456-W5-NM and 99456-W8-RE.

   28 Texas Administrative Code §134.240(1)(B) states, "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: (B) Attainment of maximum medical improvement shall be billed and reimbursed in accordance with §134.250 of this title, and the use of the additional modifier "W5" is the first modifier to be applied when performed by a designated doctor."

   28 Texas Administrative Code §134.250(2)(A) states, "If the examining doctor, other than the treating doctor, determines MMI has not been reached, the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this section. Modifier "NM" shall be added."

   The division finds the requestor billed for the MMI evaluation in accordance with 28 Texas Administrative Code §134.240(1)(B) and §134.250(2)(A).

   The rule addressing reimbursement for code 99456-W5-NM is found in 28 Texas Administrative Code §134.250(3)(C), "An examining doctor, other than the treating doctor, shall bill using CPT code 99456. Reimbursement shall be $350."

   The division finds the requestor is due reimbursement of $350.00 for code 99456-WP-NM.

3. The rule addressing reimbursement for code 99456-W8-RE is found in 28 Texas Administrative Code §134.235.

   28 Texas Administrative Code §134.240(1)(E) states, "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: (E) Ability of the employee to return to work shall be billed and reimbursed in accordance with §134.235 of this title, with the use of the additional modifier "W8"."

   28 Texas Administrative Code §134.235 states "The following shall apply to return to work (RTW)/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 maximum medical improvement/ impairment rating (MMI/IR) is performed or not, the reimbursement shall be $500 in accordance with §134.240 of this title 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 the requestor billed for the return to work evaluation in accordance with 28 Texas Administrative Code §134.240(1)(E) and §134.235.

   The division finds the requestor is due reimbursement of $500.00 for code 99456-W8-RE.

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 $850.00.

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 $850.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		2/8/2018
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.