TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
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# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name**
RAYMOND GLASS, DC

**Respondent Name**
NEW HAMPSHIRE INSURANCE CO

**MFDR Tracking Number**
M4-18-1626-01

**Carrier's Austin Representative**
Box Number 19

**MFDR Date Received**
JANUARY 29, 2018

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134."

**Amount in Dispute:** $500.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary**: "Gallagher Bassett Services, Inc. has issued additional payment for $500.00 for this procedure under this date of service."

**Response Submitted By:** The Law Office of Rick D. Green, PLLC

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| March 7, 2017 | CPT Code 99456-W6-RE<br>Extent of Injury Evaluation | $500.00 | $00.00 |

## *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 §134.210, effective July 7, 2016, provides the medical fee guideline for division specific services.
3. 28 Texas Administrative Code §134.235, effective July 7, 2016, sets the reimbursement guidelines for return to work evaluations.
4. Neither party to this dispute submitted copies of the explanation of benefits to support denial/reduction of payment for the disputed services.
5. 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 February 6, 2018. 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**

Is the requestor entitled to reimbursement for CPT code 99456-W6-RE?

**Findings**

1. The DWC-32 dated February 21, 2017, orders the claimant to attend a Designated Doctor examination with Dr. Glass for extent of injury evaluation.

   The requestor billed $500.00 for CPT codes 99456-W6-RE. Because explanation of benefits were not submitted by either party to this dispute, the division will determine if reimbursement is due per the fee guideline.

2. CPT Code 99456-W6-RE:

   To determine if reimbursement is due the division refers to the following statute:

   - 28 Texas Administrative Code §134.210(e)(21) states, “The following division modifiers shall be used by health care providers billing professional medical services for correct coding, reporting, billing, and reimbursement of the procedure codes: W6, 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 injured employee's compensable injury.”

   - 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 requestor billed CPT code 99456-RE-W6 in accordance with 28 Texas Administrative Code §134.210 and §134.235; therefore, the requestor is due $500.00.

   - The respondent wrote, “Gallagher Bassett Services, Inc. has issued additional payment for $500.00 for this procedure under this date of service.” Because payment has been issued additional reimbursement is not due.

**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 | Medical Fee Dispute Resolution Officer | 06/20/2018<br>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**.