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 W. KENNEDY JR, MD

Respondent Name
TRUMBULL INSURANCE CO

MFDR Tracking Number
M4-18-4071-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
JUNE 22, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "[Claimant] was scheduled by the insurance adjuster for a Post DD-RME to address MMI, IR and Return to work…Total allowable per the Fee Schedule is $1,000.00. It appears that the insurance company is auditing with the tier which is incorrect."

Amount in Dispute: $250.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Provider is not billing appropriately. 99456/W5 billed with modifier RE is not correct. RE should only be billed with modifier W6-W9….Bill is priced correct per provider billing."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 5, 2018	CPT Code 99456-W5-RE-WP	$0.00	$0.00
	CPT Code 99456-W8-RE	$250.00	$0.00
TOTAL		$250.00	$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 §134.235, effective July 7, 2016, sets the reimbursement guidelines for return to work evaluations.
3. 28 Texas Administrative Code §134.210, effective July 7, 2016, sets out the reimbursement guidelines for division specific services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 59-Processed based on multiple or concurrent procedure rules.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.

Issues

Is the requestor entitled to additional reimbursement for CPT code 99456-W8-RE?

Findings

On the disputed date of service the requestor billed CPT codes 99456-W8-RE and 99456-W5-RE-WP. Only CPT code 99456-W8-RE is in dispute. According to the explanation of benefits, the respondent paid $500.00 for CPT code 99456-W8-RE based upon the fee guideline.

To determine if the requestor is due additional payment the division refers to the following statute:

- Per 28 Texas Administrative Code §134.203(a)(5), "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."
- 28 Texas Administrative Code §134.210(b)(2) states, "Modifying circumstance shall be identified by use of the appropriate modifier following the appropriate Level I (CPT codes) and Level II HCPCS codes. Where HCPCS modifiers apply, insurance carriers shall treat them in accordance with Medicare and Texas Medicaid rules. Additionally, division-specific modifiers are identified in subsection (e) of this section. When two or more modifiers are applicable to a single HCPCS code, indicate each modifier on the bill."
- 28 Texas Administrative Code §134.210(e)(23) 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: W8, designated doctor examination for return to work--This modifier shall be added to the appropriate examination code performed by a designated doctor when determining the ability of injured employee to return to work."
- 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 Division ordered the claimant to attend a Designated Doctor Examination for MMI/IR and Return to Work evaluation with Dr. Charles W. Kennedy.
- On the disputed date of service the requestor billed CPT codes 99456-W8-RE and 99456-W5-RE-WP.
- The requestor billed for the return to work examination with CPT code 99456-W8-RE in accordance with 28 Texas Administrative Code §134.210 and §134.235.
- Per 28 Texas Administrative Code §134.235, the MAR for 99456-W8-RE is $500.00.

- Per the submitted explanation of benefits, the respondent paid $500.00 for code 99456-W8-RE; therefore, 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

		8/30/2018
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, 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.