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
VALORIE ROBERTSON, MD

Respondent Name
ZURICH AMERICAN INSURANCE CO

MFDR Tracking Number
M4-19-0369-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
SEPTEMBER 24, 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: $250.00

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
February 21, 2018	CPT Code 99456-NM Designated Doctor Evaluation	$0.00	$0.00
	CPT Code 99456-RE Extent of Injury Evaluation	$0.00	$0.00
	CPT Code 99456-RE Liability/Compensability Evaluation	$250.00	$250.00
	CPT Code 99456-MI Return to Work Evaluation	$0.00	$0.00
	CPT Code 99080 Report	$0.00	$0.00
TOTAL		$250.00	$250.00

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, effective May 31, 2012, 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. 28 Texas Administrative Code §134.240, effective July 7, 2016, sets the reimbursement guidelines for Designated Doctor Examinations.
5. The services in dispute were reduced / denied by the respondent with the following reason codes:
   - W3.

Issues

Is the requestor entitled to reimbursement for 99456-RE?

Findings

On the disputed date of service the requestor billed $1,215.00 for Post-Designated Doctor Examination with CPT codes 99456-NM, 99456-RE (X2), 99456-MI and 99080-73. The respondent paid $965.00. The requestor is seeking medical fee dispute resolution for $250.00 for code 99456-RE.

28 Texas Administrative Code §134.210(b)(2) states, "Payment policies relating to coding, billing, and reporting for workers' compensation specific codes, services, and programs are as follows: 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) 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:

(5) MI, multiple impairment ratings--This modifier shall be added to CPT code 99455 when the designated doctor is required to complete multiple impairment ratings calculations.

(6) NM, not at maximum medical improvement (MMI)--This modifier shall be added to the appropriate MMI CPT code to indicate that the injured employee has not reached MMI when the purpose of the examination was to determine MMI

(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.

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."

28 Texas Administrative Code §134.240(2)(A-C) states, "When multiple examinations under the same specific division order are performed concurrently under paragraph (1)(C) - (F) of this section:

(A) the first examination shall be reimbursed at 100 percent of the set fee outlined in §134.235 of this title;
(B) the second examination shall be reimbursed at 50 percent of the set fee outlined in §134.235 of this title; and
(C) subsequent examinations shall be reimbursed at 25 percent of the set fee outlined in §134.235 of this title."

A review of the submitted report finds the requestor addressed return to work and extent of injury examinations. The respondent paid $500.00 for the first examination and $0.00 for the second examination. Per 28 Texas Administrative Code §134.235 and 28 Texas Administrative Code §134.240(2) the requestor is due $250.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $250.00.

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 $250.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.
Authorized Signature

		1/11/2019
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.