TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
KELLEY SAMUEL, DC

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-19-2419-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JANUARY 4, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The bill is being submitted for reconsideration to assist in prompt bill payment per Rule 133.250 …for a total of $500 based on Texas state law."

Amount in Dispute: $500.00

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
November 8, 2018	CPT Code 99456-W8-RE Designated Doctor Evaluation (DD)	$500.00	$500.00

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, 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 respondent denied reimbursement for the disputed services based upon the following claim adjustment

reason codes:

- 16-Claim/service lacks information or has submission/billing error(s).
- 205-Diallowed, charges will be reviewed upon receipt of supporting info such as reports, notes, or invoice. Resubmit with original bill.

6. 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 January 15, 2019. 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-W8-RE?

Findings

1. On November 8, 2018, the claimant attended a Designated Doctor Examination to determine claimant's ability to return to work. The requestor billed the respondent $500.00 for the evaluation with CPT code 99456-W8-RE. The respondent issued payment of $0.00 due to a lack of information. The requestor submitted report to support billed service.

2. To determine the appropriate reimbursement the division refers to the following statutes:
   - 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:
     (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.
     (23) 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 §134.240(1)(C) states, "The following shall apply to designated doctor examinations. (1) 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:
     (C) Extent of the employee's compensable injury shall be billed and reimbursed in accordance with §134.235 of this title, with the use of the additional modifier "W6";

   - 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."

- 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."

3. The Division reviewed the submitted documentation and finds the following:
   - The requestor billed 99456-W8-RE for the return to work evaluation.
   - Per 28 Texas Administrative Code §134.235 the appropriate reimbursement for the evaluation is $500.00.
   - The respondent paid $0.00. The requestor is due the difference between MAR and paid of $500.00.

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 $500.00.

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 $500.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	Date
		4/4/2019

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.