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
Jason Marchetti, M.D.

Respondent Name
Arch Indemnity Insurance Company

MFDR Tracking Number
M4-19-3164-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
February 15, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I was asked to evaluate maximum medical improvement and return to work. As outlined in my report, I did not find the claimant to be at MMI and therefore billed $350 using 99456 with modifiers W5 NM. $500 was billed for the return to work analysis using 99456 modifier W8. The total for the bill is $850."

Amount in Dispute: $850.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill(s) in question was escalated and the review has been finalized. Our bill audit company has determined additional monies are owed … The provider should be billing modifier RE to advise services were for Return to Work (RTW) and/or Evaluation of Medical Care (EMC) and modifier W8 would advise type of RTW or EMC billing for."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 10, 2018	Designated Doctor Examination	$850.00	$350.00

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 sets out the fee guidelines for evaluations to determine the injured employee's ability to return to work.
3. 28 Texas Administrative Code §134.240 sets out the fee guidelines for designated doctor examinations.

4. 28 Texas Administrative Code §134. 250 sets out the fee guidelines for evaluations to determine maximum medical improvement and impairment rating.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.
   - 16 – Claim/service lacks information or has submission/billing error(s).
   - P12 – Reimbursement has been calculated according to state fee schedule guidelines.

Issues

Is Dr. Marchetti entitled to reimbursement for the examinations in question?

Findings

Dr. Marchetti is seeking reimbursement for an examination to determine maximum medical improvement for the injured employee. If the designated doctor determines that maximum medical improvement (MMI) has not been reached, the designated doctor is required to bill the examination with CPT code 99456 and modifier "NM."[1] Reimbursement is $350.00 for this examination.[2]

The submitted documentation, including the Report of Medical Evaluation (DWC069) and narrative, supports that Dr. Marchetti performed an evaluation of maximum medical improvement as ordered by the division and found that the injured employee was not at MMI. Therefore, the maximum allowable reimbursement (MAR) for this examination is $350.00. This amount is recommended.

Dr. Marchetti is also seeking reimbursement for an examination to determine if the injured employee was able to return to work. A doctor requested by the DWC or the insurance carrier is required to bill an examination to determine the ability of the injured employee to return to work with CPT code 99456 and modifier "RE."[3] A designated doctor is also required to bill this type of examination using modifier "W8."[4]

Review of the submitted documentation finds that Dr. Marchetti billed the examination to determine the ability of the injured employee to return to work using CPT code 99456 and modifier "RE," but failed to include modifier "W8." The insurance carrier's denial of this service is supported. No further reimbursement is recommended for this examination.

The total allowable reimbursement for the disputed services is $350.00. No evidence was provided to support that a reimbursement has been made to the health care provider. Reimbursement of $350.00 is recommended.

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 $350.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $350.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	April 1, 2019 Date

[1] 28 Texas Administrative Codes §§134.250(2)(A)
[2] 28 Texas Administrative Code §134.250(3)(C)
[3] 28 Texas Administrative Code §134.235
[4] 28 Texas Administrative Code §134.240(1)(E)

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §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 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. **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.