Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address:	
Brian C. Buck, M.D. P. O. Box 162370 Austin, Texas 78716-2370	MDR Tracking No.: M4-05-A764-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
American Home Assurance Company C/o Flahive Ogden & Latson Rep Box # 19	Employer's Name: SBC Communications, Inc.
	Insurance Carrier's No.: A42502004900010125

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

"…This was a carrier order Required Medical Exam (RME) where both Evaluation of Medical Care (EMC) and Return to Work (RTW) were addressed as ordered on the TWCC-22…According to the medical fee guidelines of the Texas Workers' Compensation Commission…These are separately billable services. It was clearly indicated on the TWCC-22 that Sedgwick ordered these services and clearly indicated on the HICF that we were billing for both services. "

Principle Documentation:
1. Requestor's position summary
2. TWCC 60/Table of Disputed Services
3. CMS 1500
4. Explanation of Benefits
5. TWCC-22 Required Medical Examination Notice or Request for Order, ordered by theCarrier
6. Evaluation of Medical Care Report and TWCC-73 Work Status Report dated 05/18/05

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Respondent did not submit a response to this dispute request.

Principle Documentation:
1. N/A

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	Denial Code	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
05/18/05		99456-RE-59 (Evaluation of Medical Care)	1	Not in Dispute
05/18/05		99456-RE-59 (Return To Work)	2	$350.00
TOTAL DUE				$350.00

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Section 413.011(a-d) titled (Guidelines and Medical Policies), and Commission Rule 134.202 titled (Medical Fee Guideline) effective August 1, 2003, set out reimbursement guidelines.

1. Code 99456-RE-59 (Evaluation of Medical Care) for date of service 05/18/04 was appropriately reimbursed and not in dispute.

2. Code 99456-RE-59 (Return to Work Evaluation) for date of service 05/18/04 denied as “Procedure and Services Not Normally reported Together. (EMC) RTW and/or EMC Examinations. The Requestor submitted the Return To Work report dated 05/18/05. TWCC Advisory 2004-06 states, “Billing for Return to Work (RTW) and/or Evaluation of Medical Care (EMC) exams: A carrier may request a doctor to perform an examination of the injured employee to determine the ability of the injured employee to return to work, to evaluate the medical care of the employee, or both. If the carrier asks, in a single request, for the doctor to both evaluate the medical care and to determine the ability of the injured employee to return to work, the doctor may bill and be reimbursed for each evaluation, both of which occurred in a single examination. In such cases the doctor may use modifier ‘59’ to indicate that the services performed to complete the carrier’s request were distinct or independent, but appropriate under the circumstances.” The Respondent reimbursed the Requestor $00.00. The Requestor submitted the TWCC-73 (Work Status Report) to support the services rendered. Therefore, additional reimbursement in the amount of $350.00 is recommended.

Therefore, it is the conclusion of the Medical Review Division that additional reimbursement in the amount of $350.00 is due the requestor.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.201
28 Texas Administrative Code Sec. §134.202
TWCC Advisory 2004-06

PART VII: DIVISION DECISION AND ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the Division has determined that the requestor **is** entitled to additional reimbursement in the amount of **$350.00**. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30-days of receipt of this Order.

Ordered by:

Authorized Signature	Typed Name	Date of Order
		02/02/06

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005]. An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. The Division is not considered a party to the appeal.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.