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:	
Southwest Medical Examination Services, Inc. 7502 Greenville Ave., Ste. 600 Dallas, TX 75231	MDR Tracking No.: M4-07-0129-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Old Republic Insurance Co. Rep. Box # 02	Date of Injury: Employer's Name: ICI American Holdings Inc. Insurance Carrier's No.: 39661356598911

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary:
"Billed per Advisory 2004-06."
Principle Documentation:

1. DWC-60
2. CMS-1500
3. EOBs

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary:
None submitted.

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)
9-7-05	W12	99456-RE-59 – Return to Work and Medical Evaluation	1-5	$700.00
TOTAL DUE				$700.00

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

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

1. This dispute relates to whether additional reimbursement is due for code 99456-RE-59. The insurance carrier paid $0.00 of the $700.00 billed based upon, "W12 – Distinct procedural service – procedure and services not normally reported together. Disallowed: Services do not appear related to work injury/diagnosis."

2. The Requestor performed a Designated Doctor Examination on this date; therefore, denial based upon extent of injury issue was invalid.

3. According to Rule 134.202(e)(7), "Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a commission or insurance carrier requested RTW/EMC examination that is not for the purpose of certifying MMI and/or assigning an IR (e.g., a medical necessity issue), the examining doctor shall bill and be reimbursed using the "Work related or medical disability examination by other than the treating physician…" CPT code with modifier "RE." The reimbursement shall be $350.00 and shall include commission-required reports. Testing that is required shall be billed using the appropriate CPT code and reimbursed in addition to the examination fee."

4. Advisory 2004-06, issued on May 12, 2004, stated in part that, "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."

5. On this date, the Requestor billed $700.00 for 99456-RE-59. Per Advisory 2004-06, the Requestor performed two evaluations and utilized modifier-"59" to differentiate it from a single evaluation. Therefore, Per Rule 134.202(e)(7), the Requestor is entitled to $350.00 + $350.00 = $700.00. The insurance carrier paid $0.00. The Requestor is entitled to reimbursement of $700.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 413.011(a-d)
28 Texas Administrative Code Sec. §134.1
28 Texas Administrative Code Sec. §134.202
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 $700.00 plus all accrued interest due at the time of payment to the Requestor within 30 days receipt of this Order.

Decision and Order by:

	Elizabeth Pickle, RHIA	November 17, 2006
Authorized Signature	Typed Name	Date of Decision

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.