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

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Southwest Medical Examination Services, Inc. 7502 Greenville Ave., Ste. 600 Dallas, TX 75231	MFDR Tracking #: M4-07-0650-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: City of Dallas Rep. Box #42	Date of Injury: Employer Name: City of Dallas Insurance Carrier #: 20052025

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary:

"Req test for RTW/EMC exam."

Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)
3. EOB(s)

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary:

None submitted.

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Review of the box 32 on CMS-1500, revealed zip code 75231 is located in Dallas county.

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
10-11-05	18, 97H	95834	1-3	$61.94
Total Due:				$61.94

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

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

1. These services were denied by the Respondent with reason code "18-Duplicate claim service; and 97H– Payment is included in the allowance for another service/procedure."

2. The disputed service The Respondent denied reimbursement based upon duplicate claim/service. The disputed service was a duplicate bill submitted for reconsideration of payment; therefore, the insurance carrier inappropriately denied reimbursement based upon "18."

3. According to Rule 134.202(e)(7), "Testing that is required shall be billed using the appropriate CPT code and reimbursed in addition to the examination fee." On this date, the Requestor billed CPT code 99456-RE for the examination and CPT codes 95851 and 95834 for the testing. CPT code 95834 is not global to any service billed on this date. The MAR for CPT code 95834 is $61.94, this amount is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.1, §134.202
Advisory 2004-06

PART VII: DIVISION DECISION AND/OR 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 reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $61.94 plus accrued interest, due within 30 days of receipt of this Order.

ORDER / DECISION:

	Elizabeth Pickle, RHIA	June 21, 2007
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

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.