



MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Mitchell Porias, DO 2900 Wesleyan Ste. 620 Houston, TX 77027	MFDR Tracking #: M4-07-2546-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: City of Dallas Box #42	Date of Injury:
	Employer Name: City of Dallas
	Insurance Carrier #: 20051256

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary:

"DDE billed in accord w/Rule 134.202(e)(6) carrier did not respond to Reconsideration."

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 77018 is located in Harris county.

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
7-13-06	W1, W4	99456-RE	1-3	\$0.00
Total Due:				\$0.00

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 "W1 – Workers comp state fee schedule adjustment; W4 – No additional reimbursement allowed after review of appeal/reconsideration."
2. 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."

3. On this date, the Requestor billed \$500.00 for 99456-RE. Per Rule 134.202(e)(6)(C)(iii), the Requestor is entitled to reimbursement of \$350.00 for evaluation. The insurance carrier paid \$350.00. The Requestor is not entitled additional reimbursement.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

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

PART VII: DIVISION DECISION

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 not entitled to additional reimbursement.

DECISION:

Elizabeth Pickle, RHIA

June 20, 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.