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 #: M4-07-2992-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: City of Fort Worth Rep. Box #03	Date of Injury: Employer Name: City of Fort Worth Insurance Carrier #: WC0520015145

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary:

"Billed per Advisory 2004-06; and 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:

"Since the claimant was already working full duty….a return-to-work examination was not preformed, and reimbursement for it is not due."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Review of the box 32 on CMS-1500, revealed zip code 76104 is located in Tarrant county.

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
3-2-06	18, 247, W4, 86	99456-RE-59- Evaluation for MMI/IR	1-5	$0.00
	18, 247, 309, 42, 308	95834	1-2, 6	$57.07
Total Due:				$57.07

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; 247 – Duplicate service; 309-Charge exceeds fee schedule allowance; 42-Charges exceed our fee schedule or maximum allowable amount; W4 – No additional reimbursement allowed after review of appeal/reconsideration; and 308 and 86 - undefined; "

2. 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" and "247."

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 CPT code 99456-RE-59. The Requestor indicated that the claimant had returned to work "full time, full duty and had full functional capacity with regard to her job." The insurance carrier appropriately paid $350.00 for the single evaluation, additional reimbursement is not due.

6. 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-59 for the examination and CPT code 95834 for the testing.
   - Per Commissioner's Bulletin #B-0006-06, "The CY 2005 conversion factor of $37.8975 is to be used effective immediately when calculating MAR for services provided on of after January 1, 2006." The MAR for CPT code 95834 is $59.33 or less. Per Rule 134.202(d), "reimbursement shall be the least of the (1) MAR amount as established by this rule or, (2) the health care provider's usual and customary charge." The Requestor is seeking dispute resolution in the amount of $57.07, 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 $57.07 plus accrued interest, due within 30 days of receipt of this Order.

ORDER / DECISION:

Authorized Signature	Medical Fee Dispute Resolution Officer	Date
	Elizabeth Pickle, RHIA	June 20, 2007

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.