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:	MFDR Tracking #: M4-07-4547-01
Southwest Medical Examination Serv. Inc. 7502 Greenville Ave., Ste. 600 Dallas, TX 75231	DWC Claim #:
	Injured Employee:
Respondent Name and Box #:	Date of Injury:
Atlantic Mutual Insurance Co. Box # 19	Employer Name: Staffmark Investments LLC
	Insurance Carrier #: 003960000993570

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary:

"Billed per Advisory 2004-06."

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.

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
3-23-06	B13, B6, 42	99456-RE-59	1-6	$350.00
Total Due:				

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 reduced by the Respondent based upon "B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment; 42 – Charges exceed our fee schedule or maximum allowable amount; and B6 – This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty."

2. The Respondent reimbursed the Requestor $350.00 of the $700.00 billed.

3. The insurance carrier incorrectly utilized EOB denial "B6" because provider is a medical doctor.

4. 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."

5. 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."

6. On this date, the Requestor billed $700.00 for CPT code 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 $350.00. The Requestor is entitled to additional reimbursement of $350.00.

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 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 $350.00 plus accrued interest, due within 30 days of receipt of this Order.

ORDERED BY:

	Elizabeth Pickle, RHIA	June 4, 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.