Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RGV HEALTHCARE SYSTEM
BOX 6582
MCALLEN TX 78502

Respondent Name
AMERISURE INSURANCE CO

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number
M4-10-1344-01

MFDR Date Received
OCTOBER 30, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "$0.00 paid"

Amount in Dispute: $113.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider, RGV Healthcare System has not submitted to Amerisure Mutual Insurance a REQUEST FOR RECONSIDERATION for the date of service 02/24/2009. Amerisure Mutual received the original bill date stamped 03/12/2009 (copy attached.)…The information letter was printed and mailed on 03/23/2009 to the provider…RGV Healthcare System returned the corrected billing 119 days after the Information Letter was mailed…it is our position that the bill was reviewed correctly and no reimbursement is due to this healthcare provider."

Response Submitted by: Amerisure Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 4, 2009	CPT Code 99361-W1 Medical Conference with Team	$113.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
2. 28 Texas Administrative Code §133.307, effective May 25, 2008, 33 *Texas Register* 3954, sets out the procedures for resolving a medical fee dispute.
3. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets out medical fee guidelines for workers' compensation specific services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 29-The time limit for filing has expired.

- Denial based on not timely filing as of Sept. 1, 2005 a HCP is required to submit a medical bill within 95 days of the date of service please see Commissioner Bulletin B-0037-05A

Issues

1. Were the services billed to the carrier timely?
2. Is the requestor entitled to reimbursement?

Findings

1. According to the submitted explanation of benefits, the respondent denied reimbursement for the disputed service based upon reason code "29."

   Texas Labor Code §408.027(a) states "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

   The disputed date of service is February 4, 2009. The respondent states in the position summary that they received the requestor's billing on March 12, 2009. This date is within the timeframe established in Texas Labor Code §408.027(a) for the health care provider to submit his claim; therefore, the respondent's denial based upon "29" is not supported.

2. 28 Texas Administrative Code §134.204(e)(4) states "Case management services require the treating doctor to submit documentation that identifies any HCP that contributes to the case management activity. Case management services shall be billed and reimbursed as follows:
   (A) CPT Code 99361.
   (i) Reimbursement to the treating doctor shall be $113. Modifier 'W1' shall be added."

Review of the submitted documentation finds that the requestor has not submitted a copy of the case management/team conference services; therefore, the requestor has not supported billing for CPT code 99361-W1. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	3/27/2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.