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
RIO GRANDE CITY CISD

Carrier's Austin Representative Box
Box Number 21

MFDR Tracking Number
M4-10-1476--01

MFDR Date Received
NOVEMBER 3, 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 bill does not meet the criteria for reimbursement established by Texas Department of Insurance Division of Workers Compensation Rule 134.204…The bill in question shows a charge for 99361 with modifier W1 signifying that the charge is from the treating doctor. Box 31 shows Javier Saenz, M.D. Box 33 shows that the bill is to be paid to RGV Healthcare. Review of the claim shows the treating doctor to be Javier Saenz, M.D. If RGV Healthcare is to be paid for Dr. Saenz's service, the team members appear to be employees of the same practice and the bill would not be reimbursable."

Response Submitted by: JI Specialties

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 1, 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. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets out medical fee guidelines for workers' compensation specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- W1-Workers compensation state fee schedule adjustment.
- 150-Payer deems the information submitted does not support this level of service.
- W4-No additional reimbursement allowed after review of appeal/reconsideration.
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- Case Mgmt team members cannot be employees of treating dr.

Issues

Is the requestor entitled to reimbursement?

Findings

The respondent denied reimbursement for the case management/team conference services, CPT code 99361, based upon reason code "150."

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.