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
TASB RISK MGMT FUND

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number
M4-10-1482-01

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: "According to the documentation submitted by RGV the initial team conference was between Juan Garcia, MD, Greg Luna, PAC and Gary Molina whom are all employees of RGV Healthcare System. The team conference was not done by HCP's outside the interdisciplinary program therefore no reimbursement is due."

Response Submitted by: TASB Risk Management Fund

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 23, 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

- 185-The rendering provider is not eligible to perform the service billed.
- 193-Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.

Issues

Is the requestor entitled to reimbursement?

Findings

The respondent denied reimbursement for the case management/team conference services, CPT code 99361-W1, based upon reason code "185."

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 submitted a copy of the Initial Medical Team Conference & Plan of Care report that was signed by Greg Luna PA-C and Gary Molina. Per 28 Texas Administrative Code §134.204(e)(4), code 99361-W1 is to be billed and reimbursed by the treating doctor. The documentation does not support billing the case management/team conference services per 28 Texas Administrative Code §134.204(e)(4). 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.