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
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-10-1614-01

MFDR Date Received
OCTOBER 19, 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 requestor's documentation, INITIAL MEDICAL TEAM CONFERENCE & PLAN OF CARE, identifies that Greg Luna, PA., and Gary Molina, COO, participated in this alleged case management activity. The Rule cite above clearly sets out that the conference, telephone calls, etc. are to be coordinated with an interdisciplinary team. Assuming COO to mean Chief Operating Officer, Texas Mutual argues that designation is not reflective of a health care provider participating with Mr. Luna as an interdisciplinary team…the requestor's documentation…does not identify any other healthcare provider participating in the alleged case management activity."

Response Submitted by: Texas Mutual Insurance Co.

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

- CAC-W1-Workers compensation state fee schedule adjustment.
- CAC-W4-No additional reimbursement allowed after review of appeal/reconsideration.
- 891-The insurance company is reducing or denying payment after reconsideration.
- 892-Denied in accordance with DWC rules and/or medical fee guideline.

Issues

Is the requestor entitled to reimbursement?

Findings

The respondent denied reimbursement for the case management services, CPT code 99361, based upon reason code "892."

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 INITIAL MEDICAL TEAM CONFERENCE & PLAN OF CARE report that indicates Greg Luna PA-C met with Gary Molina to discuss plan of care. The documentation does not indicate that Gary Molina is a healthcare provider, nor does it document his contribution in the case management activity; therefore, the requestor has not supported billing for the case management service.

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

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