



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

Nueva Vida Behavioral Health and Associates

Respondent Name

Insurance Co of the State of PA

MFDR Tracking Number

M4-13-1043-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

December 28, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...we are the referring HCP and we are billing for case management service..., ...we are within the medical fee guidelines to bill for this service."

Amount in Dispute: \$56.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This appears to be a staff meeting. Rule 134.204 states case management activities are the responsibility of the treating doctor primarily, but a referral provider may participate and bill for these activities. This was not a referral provider. An interdisciplinary team may not include employees of the coordinating provider. The fact that the involved group all work at same location with treating doctor makes it not payable (Staff meetings are not separately reimbursable.)"

Response Submitted by: AIG, P.O. Box 25794, Shawnee Mission, KS 66225

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 29, 2012 April 25, 2012	99361	\$56.00	\$28.00

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 sets out the reimbursement guidelines for case management services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
 - This service/supply is not covered according to the state fee schedule guidelines.
 - Our position remains the same if you disagree with our decision please contact the TWCC Medical Dispute Resolution.

Issues

1. Did the requestor submit required documentation as required by rule 134.204?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed services as, 97 – “The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.” 28 Texas Labor Code §134.204(e) (4) states in pertinent part, “Case management services require the treating doctor to submit documentation that identifies any HCP that contributes to the case management activity.” Review of the submitted documentation finds the following;
 - a. Case management note dated January 19, 2012 states, “General Purpose: Care Coordination” “Specific Purpose: Coordinating Care” “Outcome: Referral to community agency for other health needs. The patient will be ordered to have a functional capacity evaluation; mental health testing for interdisciplinary care. The patient will maintain medication management with Dr. Stephenson.”

Review of the submitted documentation finds nothing to support the treating physician participated in the case management service. The requirements of Division rules not met. No additional payment can be recommended.

For dates of service April 19, 2012, review of the submitted documentation finds;

- a. Dr. Douglas Burke DC is the referring physician
- b. Case management note dated April 25, 2012 indicates signatures of participants. Douglas Burke, appears to have been present at the time of service. There is no documentation available to support the carrier’s claim “the fact that the involved group all work at same location with treating doctor makes it not payable (Staff meetings are not separately reimbursable.” The carrier’s denial is not supported for this date of service.

2. 28 Texas Administrative Code 134.202(e)(4) 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. (ii) Reimbursement to the referral HCP shall be \$28 when a HCP contributes to the case management activity.” The maximum allowable reimbursement for the services in dispute is \$28.00. This amount is recommended for date of service April 25, 2012.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$28.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$28.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

August 21, 2014
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request 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 §141.1(d).

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