



**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](http://www.tdi.texas.gov)

**MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

**GENERAL INFORMATION**

**Requestor Name**

G. PETER FOOX, MD

**Respondent Name**

AIG PROPERTY CASUALTY CO

**MFDR Tracking Number**

M4-13-2680-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

JUNE 18, 2013

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Discussed need for MRI ankle."

**Amount in Dispute:** \$18.00

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** The respondent did not submit a response to this request for medical fee dispute resolution.

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 28, 2013	CPT Code 99371-W1 Case Management Services	\$18.00	\$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**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.204, effective March 1, 2008, sets out medical fee guidelines for workers' compensation specific services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
  - W1-Workers compensation state fee schedule adjustment.
  - VA07-This service/supply is not covered according to the state fee schedule guideline.
- The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on June 26, 2013. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not

submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

**Issues**

Is the requestor entitled to reimbursement?

**Findings**

The respondent denied reimbursement for the case management services, CPT code 99371-W1, based upon reason code "VA07."

28 Texas Administrative Code §134.204(e)(1-4) states: Case Management Responsibilities by the Treating Doctor is as follows:

(1) Team conferences and telephone calls shall include coordination with an interdisciplinary team.

The requestor noted that the telephone conversation was with the carrier's representative Dr. Ford not with an interdisciplinary team.

(A) Team members shall not be employees of the treating doctor.

The requestor noted that Dr Ford was employed by the insurance carrier.

(B) Team conferences and telephone calls must be outside of an interdisciplinary program. Documentation shall include the purpose and outcome of conferences and telephone calls, and the name and specialty of each individual attending the team conference or engaged in a phone call.

The documentation does not indicate that claimant was participating in an interdisciplinary program. Dr. Foox noted that the purpose of the telephone conversation was to discuss the need for an ankle MRI.

(2) Team conferences and telephone calls should be triggered by a documented change in the condition of the injured employee and performed for the purpose of coordination of medical treatment and/or return to work for the injured employee.

No documentation was submitted to support that the telephone call was triggered by a documented change in the claimant's condition.

Review of the Telephone Conference at Carrier's request report does not meet the requirements outlined in 28 Texas Administrative Code §134.204(e)(1-2). As a result, reimbursement is not recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional 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

\_\_\_\_\_  
Date

11/25/2014

## ***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.**