



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

ELITE HEALTHCARE FORT WORTH

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-14-3131-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

JUNE 13, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: Patient was present for a team conference in our office. Our office professionals that were in the meeting documented the patients progress as to date. Patient has had this claim before and paid in full, 3 previous dates."

Amount in Dispute: \$113.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed code 99361 for a team conference. Review of sections (e) of Rule 134.204 indicates the requestor's documentation does not meet the criteria for the use of code 99361."

Response Submitted By: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 28, 2014	CPT Code 99361-W1 Case Management Services	\$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:
- CAC-W1-Workers compensation state fee schedule adjustment.
 - 744-Does not meet the definition of case management per DWC rule 134.202 and/or 134.204.
 - CAC-193- Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
 - CAC-W3, 350-In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
 - 891-No additional payment after reconsideration.

Issues

Did the requestor support billing the medical conference in accordance with 28 Texas Administrative Code §134.204? Is the requestor entitled to reimbursement?

Findings

The respondent denied reimbursement for the case management services, CPT code 99361, based upon reason code "744"

28 Texas Administrative Code §134.204(e)(2) states: "Case Management Responsibilities by the Treating Doctor is as follows: 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."

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. The requestor billed CPT code 99361-W1; however, the documentation does not support that the treating doctor participated in the case management service.

Review of the submitted TEAM CONFERENCE report finds that the requestor listed the participants in the conference; however, the record does not document that it was 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. 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

01/29/2015

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.