



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

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-14-1784-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

FEBRUARY 20, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "we are the referring HCP and we are billing for case management services.."

Amount in Dispute: \$84.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed code 99361 for services provided 3/18/13...The documentation for this date does not rack to any return to work. One specific purpose was to clarify/alter previous instructions yet there is no explanation or apparent explication of what is being clarified or altered. The same logical weakness characterizes the second specific purpose of revising the treatment plan. For example, 'reschedule benefit review conference' has absolutely nothing to do with the delivery of healthcare by the requestor. One sees the same problems with 99361 billed for dates 7/1/13 and 9/9/13. No payment is due."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 18, 2013 July 1, 2013 September 9, 2013	CPT Code 99361 Case Management Services	\$28.00 X 3 = \$84.00	\$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:
 - CAC-W1-Workers compensation state fee schedule adjustment.
 - CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
 - 744-Does not meet the definition of case management per DWC Rule 134.202 and/or 134.204.

- 891-No additional payment after reconsideration.
- 892-Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions.

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."

Review of the submitted CASE MANAGEMENT NOTE report finds that the requestor listed the participants in the conference; however, the record does not meet requirements outlined in 28 Texas Administrative Code §134.204(e)(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.