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

Respondent Name
City Of Fort Worth

MFDR Tracking Number
M4-14-2322-01

Carrier's Austin Representative
Box Number 04

MFDR Date Received
March 28, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "These denials are incorrect. Team members are not employees of the treating provider. They are employees of Elite Healthcare, same as the treating provider being employee of Elite Healthcare."

Amount in Dispute: $113.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Documentation indicates the participants of the team conference are all members of the same organization. The treating doctor on record is Michael Lopez, DC. Elite Healthcare of Ft. Worth is therefore ineligible to charge for what is essentially an internal meeting of the treating doctors employees. As such, we respectfully submit that no additional allowance is recommended."

Response Submitted by: CorVel Corporation, 3721 Executive Center Drive, Suite 201, Austin, TX 78731

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 20, 2013	99361	$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 sets out guidelines for case management.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - B15 – Procedure/Service is not paid separately
   - 193 – Original payment decision maintained

Issues

1. Did the requestor support the services are separately payable?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed services as, B15 – "Procedure/Service is not paid separately." 28 Texas Administrative Code §134.204(e) states in pertinent part, "Case Management Responsibilities by the Treating Doctor is as follows: (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." Review of the submitted "Team Conference" from 9/20/13 finds;
    a. "Has completed 3 of 5 visits of post-op PT"

   This document does not support a change in condition. The carrier's denial is supported.
2. The requirements of Rule 134.204 were not met. No additional payment can be 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	December 23, 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.