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
WAL MART ASSOCIATES INC

MFDR Tracking Number
M4-15-1324-01

Carrier's Austin Representative
Box Number 53

MFDR Date Received
DECEMBER 31, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Patient has had same service pervious [sic] and was paid in full."

Amount in Dispute: $113.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This request for medical dispute resolution should be dismissed…Carrier has disputed that the compensable injury extends to and includes these diagnostic codes and conditions."

Response Submitted By: Hoffman Kelley

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 6, 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:
   - B14-Payment denied because only one visit or consultation per physician per day is covered.
   - 53-Two evaluations/visits have been inappropriately billed on the same date of service.
   - W3-Additional payment made on appeal/reconsideration.
   - 6611-Reviewed by RSL.

Issues

1. Does a compensability issue exist in this dispute?
2. Does the submitted documentation support the respondent's denial based upon "B14"?

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

Findings

1. The respondent states in the position summary that "This request for medical dispute resolution should be dismissed…Carrier has disputed that the compensable injury extends to and includes these diagnostic codes and conditions."

   28 Texas Administrative Code §133.307(d)(2)(F) states "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MFDR will be dismissed in accordance with subsection (f)(3)(B) or (C) of this section.

   A review of the submitted documentation does not support that the disputed services on the disputed date were denied based upon compensability, extent of injury, liability prior to dispute resolution; therefore, a compensability issue does not exist in this dispute.

2. The respondent denied reimbursement for the case management services, CPT code 99361, based upon reason codes "B14 Payment denied because only one visit or consultation per physician per day is covered." A review of the submitted documentation does not support more than one visit or consultation per physician was rendered on the disputed date of service; therefore, the respondent's denial based upon reason code "B14" is not supported.

3. 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. 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	03/27/2015 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.