



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Elite Healthcare Fort Worth

Respondent Name

Travelers Companies Inc

MFDR Tracking Number

M4-15-2079-01

Carrier's Austin Representative

Box Number 05

MFDR Date Received

March 10, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier has paid same service for this patient 3 previous times since the beginning of treatment. All of this documentation was sent in for reconsideration to the carrier. This is an approved case with all other claims being paid in full."

Amount in Dispute: \$113.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In this case, Requestor did not include any documentation regarding the participants in the team conference, the purpose of the conference or its outcome. Accordingly, it is not entitled to reimbursement."

Response Submitted by: Flahive, Ogden, & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 15, 2014	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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.204 sets out the reimbursement guidelines for workers' compensation specific services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies
 - 193 – Original payment decisions is being maintained

Issues

1. What is the applicable ruler pertaining to reimbursement?
2. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §134.204(e)(3) states in pertinent part, "Case Management is the responsibility of the treating doctor. Team conferences and phone calls shall include coordination with an interdisciplinary team (members shall not be employees of the coordinating HCP and the coordination must be outside of an interdisciplinary program). Documentation shall include the name and specialty of each individual attending the team conference or engaged in a phone call. Team conferences and phone 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. Contact with one or more members of the interdisciplinary team more often than once every 30 days shall be limited to the following:

- (A) the development or revision of a treatment plan;
- (B) to alter or clarify previous instructions;
- (C) to coordinate the care of employees with catastrophic or multiple injuries requiring multiple specialties; or,
- (D) to coordinate with the employer, employee, and/or an assigned medical or vocational case manager to determine return to work options."

Review of the submitted documentation finds

- a) No change in the condition found on document titled "Team Conference" with date August 15, 2014

The Division finds the criteria for the service in dispute is not met as the submitted documentation contained no documented change in the condition of the patient. No additional payment can be recommended.

2. The requirements of Rule 134.202 (e)(3) 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	May 13, 2015 Date
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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, 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 MFDR 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.