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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Elite Healthcare Garland

Respondent Name
TX Public School WC Project

MFDR Tracking Number
M4-19-0563-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
October 2, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I've attached medical documentation supporting the service billed..."

Amount in Dispute: $113.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CRF contends there is insufficient documentation to support that Elite billed for a medical conference in accordance with provisions of Rule 134.204."

Response Submitted by: Creative Risk Funding

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 13, 2018	99361 -W1	$113.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 §134.200 sets out guidelines for case management
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - 112 – Service not furnished directly to the patient and/or not documented
    - 193 – Original payment decision is being maintained

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

1. The requestor is seeking reimbursement of $113.00 for professional services rendered on July 13, 2018. The insurance carrier denied disputed services with claim adjustment reason code 112 – "Service not furnished directly to the patient and/or not documented."

   28 TAC §134.220 (2) states in pertinent parts,

   > 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 document titled, "Team Conference" found

   - Progress: Patient reports no change in symptoms
   - Treatment Plan: Continue with WH Program

   Based on review of the submitted documentation, the requirements of 28 TAC §134.220 were not met. The carrier's denial is supported. No additional reimbursement is documented.

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 on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 2, 2018 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §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 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. **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.