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 North Dallas

Respondent Name
Worth Casualty Co

MFDR Tracking Number
M4-19-2044-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
December 10, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Denying Team Conferences as employees are employees by HCP is incorrect. The employees that have signed and documents are employees of Elite Healthcare North Dallas."

Amount in Dispute: $113.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on review of the documentation submitted for date of service 08/31/18 there is no noted change in the injured employee's condition or RTW status to substantiate the need to conduct a team conference."

Response Submitted by: Redpoint Insurance Group

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 31, 2018	99361	$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 §134.204 sets out the reimbursement guidelines for workers compensation specific services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 234 – This procedure is not paid separately

Issues

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

Findings

1. The requestor is seeking $113.00 for professional medical services rendered on August 31, 2018. The insurance carrier denied as, 234 – "This procedure is not paid separately." 28 Texas Administrative Code §134.204 (e) (2) states,

   > (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 documentation found insufficient information to identify the conference was triggered by a documented change in the condition of the injured employee and was performed for the purpose of coordination of medical treatment and/or return to work for the injured employee. For that reason, the insurance carrier's denial reason is supported. Additional reimbursement cannot 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

		January 4, 2019
Signature	Medical Fee Dispute Resolution Officer	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, 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.