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
Trumbull Insurance Co

MFDR Tracking Number
M4-19-4897-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
July 16, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Authorization is not required for this type of service."

Amount in Dispute: $113.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our investigation shows the following: CPT 99361 is not a valid CPT code per NCCI Edits."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 29, 2019	99361	$113.00	$113.00

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. 28 Texas Administrative Code 134.600 sets out requirements of prior authorization.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    1. 197 – Payment denied/reduced for absence of precertification/authorization
    2. APPR – Reimbursement is being withheld as the treating doctor and/or services rendered were not approved based upon handler review.

Issues

1. Are the insurance carrier's reasons for denial of payment supported?
2. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking $113.00 for professional medical services rendered on March 29, 2019. The insurance carrier denied as 197 – Payment denied/reduced for absence of precertification/authorization.

   Pre-authorization requirements are found in 28 TAC 134.600 (p) and details non-emergency health care that requires preauthorization. Code 99361 - case consultation/team conference is not included in this rule. The insurance carriers' denial is not supported.

2. 28 Texas Administrative Code §134. (e) (4) states in pertinent part,
   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

   Based on the above, the requested amount of $113.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $113.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $113.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

		August 9, 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.