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, INC

Respondent Name
CHUBB INDEMNITY INSURANCE CO

MFDR Tracking Number
M4-20-1364-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
JANUARY 31, 2020

REQUESTOR'S POSITION SUMMARY

The requestor did not submit a position summary in the request for medical fee dispute resolution.

Amount in Dispute: $113.00

RESPONDENT'S POSITION SUMMARY

"CorVel will maintain the requestor, Elite Healthcare North Dallas is entitled to $0.00 reimbursement for date of service 09/05/19 based on failure to substantiate a separately payable service."

Response Submitted By: Corvel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 5, 2019	Case Management Services CPT Code 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 (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307, effective May 31, 2012, sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.220, effective July 7, 2016, provides the medical fee guidelines for case management services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 234-This procedure is not paid separately.
   - W1-Case management services.

Issues

Is the requestor entitled to reimbursement for case management services rendered on September 5, 2019?

Findings

1. Elite Healthcare North Dallas (requestor) is seeking medical dispute resolution for case management services, CPT code 99361-W1, rendered September 5, 2019.
2. Protective Insurance Co (respondent) denied reimbursement for the case management services based upon "234-This procedure is not paid separately".
3. The fee guidelines for disputed services is found at 28 Texas Administrative Code §134.220.
4. 28 TAC §134.220(1) states, "Case management responsibilities by the treating doctor are as follows:

   (1) Team conferences and telephone calls shall include coordination with an interdisciplinary team.
   (A) Team members shall not be employees of the treating doctor.

   (B) Team conferences and telephone calls must be outside of an interdisciplinary program. Documentation shall include the purpose and outcome of conferences and telephone calls, and the name and specialty of each individual attending the team conference or engaged in a phone call."

   The submitted "Team Conference" report does not document the purpose and outcome of the conference; it does not specify that the team members are not employees of the treating doctor; and that the conference was not part of an interdisciplinary program. The DWC finds the requestor did not comply with the requirements outlined in 28 TAC §134.220(1).
5. 28 TAC §134.220(2) states, "Case management responsibilities by the treating doctor are as follows:

   (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."

   The submitted "Team Conference" report does not document a change in the injured employee's condition or that it was performed for the purpose of coordinating medical treatment and/or returning the injured employee to work. The DWC finds the requestor did not comply with the requirements outlined in 28 TAC §134.220(2).

   The requestor billed $113.00 for CPT code 99361-W1 in accordance with 28 TAC §134.220(4).
6. Based upon the above findings the DWC finds the requestor did not support billing CPT code 99361-W1 per 28 TAC §134.220(1) and (2).

Conclusion

For the reasons stated above, the DWC 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 DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	02/27/2020 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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.