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
Chubb Indemnity Insurance Co

Respondent Name
Chubb Indemnity Insurance Co

MFDR Tracking Number
M4-20-2708-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
July 15, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Not only should this service be paid in full as team conferences considered to be an essential part of a patient's clinical treatment, the denial reasons are also not consistent."

Amount in Dispute: $113.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CoreVel will maintain the requestor, Elite Healthcare North Dallas is entitled to $0.00 reimbursement for date of service 04/27/20 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
April 27, 2020	Professional Medical Services	$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 §134.220 sets out the criteria 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 insurance carrier's denial of payment supported?

Findings

The requestor is seeking reimbursement of $113.00 for professional services rendered in April 2020. The insurance carrier denied as not separately reimbursable.

The requirements of case management services is outlined in 28 TAC 134.220 (1) and states in pertinent part 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 details of the claimants' progress and treatment plan. Insufficient evidence was found to supported the requirements of the stated rule. The insurance carrier's denial is supported.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has not established payment 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

		August 5, 2020
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 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to 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 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.