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
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-21-0965-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
FEBRUARY 22, 2021

REQUESTOR'S POSITION SUMMARY

"The dates of service were previously denied for 'extent of injury' and 'exact duplicate claim service' There has been no payment for these services, and we argue that extent of injury is a reasonable reason for denial on these claims as she has been treating for the same injury and they have previously paid on these 99361 services."

Amount in Dispute: $226.00

RESPONDENT'S POSITION SUMMARY

"Our initial response to the above referenced medical fee dispute resolution is as follows: we have escalated the bills in question for bill review audit and payment."

Supplemental Response: "Our supplemental response for the above referenced medical fee dispute resolution remains pending as it is under legal review for further response."

Responses Submitted By: Gallagher Bassett Services

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 28, 2020 June 23, 2020	CPT Code 99361-W1 Case Management Services	$113.00 x 2 = $226.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 Texas Administrative Code §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:
   - 219-Based on extent of injury.
   - 11460, 00563, ZK10-Resolution manager denial.
   - B13-Previously paid. Payment for this claim/service may have been provided in a previous payment.
   - 18-Exact duplicate claim/service.

Issues

Is the requestor entitled to reimbursement for case management services rendered on May 28 and June 23, 2020?

Findings

1. The requestor is seeking medical dispute resolution in the amount of $113.00 per day for a total of $226.00 for case management services, CPT code 99361-W1, rendered on May 28 and June 23, 2020.
2. The respondent denied reimbursement for CPT code 99361-W1 based upon extent of injury.

   28 TAC § 133.307(d)(2)(H) states,

   > Responses. Responses to a request for MFDR must be legible and submitted to the division and to the requestor in the form and manner prescribed by the division (2) Response. On receipt of the request, the respondent must provide any missing information not provided by the requestor and known to the respondent. The respondent must also provide the following information and records: (H) If the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier must attach any related Plain Language Notice in accordance with §124.2 of this title (concerning Insurance Carrier Reporting and Notification Requirements).

   The respondent did not submit any plain language notices with the response; therefore, the respondent did not support the denial of payment based upon extent of injury. The DWC finds reimbursement is recommended for the disputed services.
3. The fee guidelines for disputed services is found at 28 TAC §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).
6. 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 coordination 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).

7. 28 TAC §134.220(4) states, "Case management responsibilities by the treating doctor are as follows:

   (4) Case management services require the treating doctor to submit documentation that identifies any health care provider 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."

   The submitted report indicates the healthcare professionals that participated in the conference, it does not identify what they contributed to the activity.

8. Based upon the above findings the DWC finds the respondent's denial of payment for CPT code 99361-W1 is supported because the "Team Conference" report does not meet documentation requirements found in 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

		04/19/2021
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, 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 MDR 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 DWC. **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.