



# 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 Garland

**Respondent Name**

Texas Mutual Insurance Co

**MFDR Tracking Number**

M4-21-1079-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

March 1, 2021

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "Team conferences are an essential part of a patients' clinical treatment are are necessary as a patient's condition improves or worsens."

**Amount in Dispute:** \$226.00

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Texas Mutual reviewed the billing and attached documentation and concluded it does not meet the criteria for the code at €(4)(A) of the Rule."

**Response Submitted by:** Texas Mutual

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 21, 2020 August 12, 2020	99361	\$226.00	\$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**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.203 sets out the guidelines for professional services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - P12 – Workers compensation jurisdictional fee schedule adjustment
  - 744 – Does not meet the definition of case management per DWC Rule 134.220 and/or 134.204

**Issues**

Is the insurance carrier’s denial of payment supported?

**Findings**

The requestor is seeking reimbursement of professional medical services rendered in April and August of 2020. The insurance carrier denied the disputed service as definition of case management not met.

28 TAC §134.204(e)(2) states 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 “Team Conference” does not indicate changes in condition. The insurance carrier’s denial is supported. No payment is recommended.

**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**

		March 29, 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 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.**