TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Peak Integrated Healthcare

Respondent Name
Zenith Insurance Co

MFDR Tracking Number
M4-22-1378-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
March 8, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 2, 2021	99361-W1	$113.00	$0.00
November 11, 2021	99361-W1	$113.00	$0.00
	Total	$226.00	$0.00

Requestor's Position

The requestor did not include a position statement but did include a copy of their reconsideration that states, "Please see the attached medical documentation supporting the exclusivity and necessity of CPT99361-W1 and reprocess for payment in full."

Amount in Dispute: $226.00

Respondent's Position

Upon further review, no addition allowance is recommended. To report this code include: team members should not be employees of the treating doctor, must be an interdisciplinary team, each team member must have treated the patient within 30 days of conference."

Response submitted by: Zenith Insurance Co

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.204 sets out the medical fee guidelines for Workers' Compensation Specific Services.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- 16 – Claim/service lacks information or has submission error(s)
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
- 205 – This charge was disallowed as additional information/definition is required to clarify service/supply rendered

Issues

1. Is the insurance carrier's denial based on lack of documentation supported?

Findings

1. The requestor is seeking reimbursement of team conferences. DWC Rule 134.804 (e) states in pertinent part,

   (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.

   (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.

Review of the submitted documentation was insufficient to support the purpose and outcome of the conference or a documented change in the condition of the injured employee.

The insurance carrier's denial is supported. No additional payment is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 4, 2022 Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.