



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Peak Integrated
Healthcare

Respondent Name

Texas Mutual Insurance

MFDR Tracking Number

M4-22-2134.01

Carrier's Austin Representative

Box Number 54

DWC Date Received

May 31, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 17, 2021	99361	\$113.00	\$0.00
Total		\$113.00	\$0.00

Requestor's Position

"Carrier is not paying CPT code 99361 with modifier "W1" stating it is "not a valid procedure code." According to Texas Administrative Code website, this code is valid and billable."

Amount in Dispute: \$113.00

Respondent's Position

The Austin carrier representative for Texas Mutual is Texas Mutual. The representative was notified of this medical fee dispute on June 7, 2022.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

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 §134.220 sets out billing and fee guidelines for workers' compensation specific services.

Denial Reasons

The insurance carrier did not process the medical bill for the disputed service stating the submitted code was invalid.

Issues

1. Is the insurance carrier's reason for not processing the claim supported?
2. Did the requestor meet the requirements of billing for a team conference?

Findings

1. The insurance carrier returned the claim for date of service September 17, 2021, for Code 99361 stating not a valid procedure code. DWC Rule §134.220 (4) (A) (i) states 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 CPT code 99361. Reimbursement to the treating doctor shall be \$113. Modifier "W1" shall be added. The insurance carrier's return of the medical bill is not supported. Code 99361 will be reviewed per applicable fee guidelines.
2. DWC Rule §134.220 (2) 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 "Team Conference" found insufficient information to support a documented change in condition the requirements of applicable rule is not met. No 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

_____	_____	September 13, 2022
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 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 electrónico CompConnection@tdi.texas.gov.