Division of Workers' Compensation

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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Peak Integrated Healthcare

Respondent Name
Liberty Insurance Corp

MFDR Tracking Number
M4-23-0383-01

Carrier's Austin Representative
Box Number 1

DWC Date Received
October 13, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 2, 2022	99213	$0.00	$0.00
February 24, 2022	99361-W1	$85.00	$0.00
	Total	$85.00	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR but did submit a copy of their reconsideration that states, "The date of service was denied full payment. This is incorrect. The allowable billed amount is $113 per TDI's Medical Fee Guidelines and should be paid in full"

Amount in Dispute: $85.00

Respondent's Position

This bill has been reviewed and payment has been issued correctly as MOD-W1 has not been billed by the provider."

Response submitted by: Liberty Mutual

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 §1340200 sets out the billing requirements of case management.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- 309 – The charge for this procedure exceeds the fee schedule allowance

Issues

1. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking reimbursement of case management services. The insurance carrier states in their position statement, "MOD W1 has not been billed by the provider."

   DWC Rule §134.220 (4) (A) details the billing instructions for case management services as follows. 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.

   (ii) Reimbursement to the referral health care provider shall be $28 when a health care provider contributes to the case management activity.

   Review of the submitted medical bill indicates code 99361 but the W1 modifier was not submitted. No additional reimbursement 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 entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

		March 10, 2023
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 electronico CompConnection@tdi.texas.gov.