**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 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name**
NUEVA VIDA BEHAVIORAL HEALTH

**Respondent Name**
TEXAS MUTUAL INSURANCE CO

**MFDR Tracking Number**
M4-12-2673-01

**Carrier's Austin Representative**
Box Number 54

**MFDR Date Received**
APRIL 19, 2012

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "The claim was denied by the carrier per 'workers compensation state fee schedule adjustment, and does not meet the definition of case management…Our documentation clearly shows this information and the purpose of the conference."

**Amount in Dispute:** $112.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Texas Mutual maintains its position that the documentation does not appear to meet the definition of case management from Rules 134.202 and 134.204."

**Response Submitted by:** Texas Mutual Insurance Co.

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| April 11, 2011<br>May 23, 2011<br>August 8, 2011<br>November 28, 2011 | CPT Code 99361<br>Case Management Services | $28.00 X 4 =<br>$112.00 | $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.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets out medical fee guidelines for workers' compensation specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-W1-Workers compensation state fee schedule adjustment.
   - 744-Does not meet the definition of case management per DWC Rule 134.202 and/or 134.204.
   - 891-No additional payment after reconsideration.
   - 892-Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions.

- CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

**Issues**

Is the requestor entitled to reimbursement?

**Findings**

The respondent denied reimbursement for the case management services, CPT code 99361, based upon reason codes "744-Does not meet the definition of case management per DWC Rule 134.202 and/or 134.204," and "892-Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions."

The respondent maintains the denial of reimbursement based upon "the documentation does not appear to meet the definition of case management from Rules 134.202 and 134.204."

28 Texas Administrative Code §134.204(e)(1-4) states: Case Management Responsibilities by the Treating Doctor is 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.
(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.
(3) Contact with one or more members of the interdisciplinary team more often than once every 30 days shall be limited to the following:
(A) coordinating with the employer, employee, or an assigned medical or vocational case manager to determine return to work options;
(B) developing or revising a treatment plan, including any treatment plans required by Division rules;
(C) altering or clarifying previous instructions; or
(D) coordinating the care of employees with catastrophic or multiple injuries requiring multiple specialties
(4) Case management services require the treating doctor to submit documentation that identifies any HCP 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 HCP shall be $28 when a HCP contributes to the case management activity.

Review of the submitted CASE MANAGEMENT NOTE report finds that the requestor did not meet requirements outlined in 28 Texas Administrative Code §134.204(e)(2). As a result, reimbursement is not recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | 07/03/2014<br>Date |
|---|---|---|

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.