



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Peak Integrated
Healthcare

Respondent Name

American Zurich Insurance Co

MFDR Tracking Number

M4-24-2532-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

July 18, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 4, 2024	99361-W1	\$113.00	\$113.00
May 2, 2024	99213	\$185.89	\$0.00
Total		\$298.89	\$113.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a copy of their reconsideration dated May 21, 2024 and July 18, 2024 that states, "...we are treating for the compensable injury..."

Amount in Dispute: \$298.89

Respondent's Position

The Austin carrier representative for American Zurich Insurance Co is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on July 23, 2024.

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.

Response submitted by n/a

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 Texas Administrative Code \(TAC\) §133.307](#) sets out the procedures for resolving medical fee disputes.
2. [28 TAC §134.203](#) sets out the reimbursement guidelines for professional medical services.
3. [28 TAC §134.204](#) sets out the billing and payment guidelines for team conferences.

Denial Reasons

- 11 – The diagnosis is inconsistent with the procedure.

Issues

1. What is the rule applicable to reimbursement of team conference?
2. Did the requestor support documentation requirements of physician office visit?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of the following codes.
 - 99213 – Date of service May 2, 2024. "Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and **low level** of medical decision making."
 - 99361 W1 - Date of service April 5, 2024. "Medical conference by a physician with interdisciplinary team of health professionals or representative of community agencies to coordinate activities of patient care (patient not present; approximately 30 minutes.)"

DWC Rule 28 Texas Administrative Code §134.203(a)(5) states in pertinent parts, "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

Review of the "Encounter" dated May 2, 2024 found the level of medical decision making was **straightforward**. The documentation requirements of the submitted code 99213 are not met. No payment is recommended.

2. DWC Rule 28 TAC §134.204 (e)(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" indicates the patient was requesting to return to work full duty and scheduled for designated doctor exam and continuation of home exercise program. Based on this review the documentation requirements were met.

DWC Rule 28 TAC §134.204 (e)(4)(A)(i) states, "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: CPT Code 99361. Reimbursement to the treating doctor shall be \$113. Modifier "W1" shall be added." Reimbursement in the amount of \$113.00 is recommended.

3. The total allowable DWC guideline reimbursement fee is \$113.00. This amount 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 established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that American Zurich Insurance Co must remit to Peak Integrated Healthcare \$113.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

October 22, 2024

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.