TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TX HEALTH DBA INJURY 1 OF DALLAS

Respondent Name
ARCH INDEMNITY INSURANCE CO

MFDR Tracking Number
M4-18-1566-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JANUARY 25, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CPT code 97799 MR was preauthorized…Please refer to the attached for further review."

Requestor's Supplemental Position Summary: "Yes, payment was received DOS 10/06/17 and 10/09/17 were paid correctly at $360.00 but DOS 10/10/17 and 10/11/17 were paid incorrectly…We did receive the payment. On my Medical Dispute the amounts in dispute are $450.00 & $396.00. $450.00 - $432.00 = $18.00 owed. $396.00 - $360.00 = $36.00 owed."

Amount in Dispute per Updated Position Summary: $54.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "These bills were reprocessed, as additional monies were determined to be due after Clinical Validation review."

Response Submitted By: Gallagher Bassett Services

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 6, 2017 October 9, 2017 October 10, 2017 October 11, 2017	CPT Code 97799-MR (21.75 hours)	$54.00	$54.00

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 a medical fee dispute.
2. 28 Texas Administrative Code §134.230, effective July 17, 2016 sets out the reimbursement guidelines for medical rehabilitation programs.

1. The services in dispute were reduced or denied payment based upon reason code(s):

- 112-Service not furnished directly to the patient and/or not documented.

Issues

1. What is the applicable fee guideline?
2. Is the respondent's denial of payment supported?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The fee guideline for medical rehabilitation services is found in 28 Texas Administrative Code §134.230.

2. 28 Texas Administrative Code §134.230(1) states "Accreditation by the CARF is recommended, but not required. (A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the maximum allowable reimbursement (MAR). (B) If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR."

   The requestor billed 97799-MR; therefore, the disputed program is non-CARF accredited and reimbursement shall be 80% of the MAR.

   28 Texas Administrative Code §134.230(4) states, "The following shall be applied for billing and reimbursement of Outpatient Medical Rehabilitation Programs.
   (A) Program shall be billed and reimbursed using CPT code 97799 with modifier "MR" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited programs shall add "CA" as a second modifier.

   (B) Reimbursement shall be $90 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes."

   A review of the submitted medical bill indicates the requestor billed for 21.75 hours; therefore, 80% of $90.00 = $72.00 X 21.75 hours = $1,566.00. The respondent paid $1,512.00. The requestor is due the difference of $54.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $54.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $54.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	5/2/2018 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request 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 §141.1(d).

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