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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Edwin Cruz MD

Respondent Name
Indemnity Insurance Co of North America

MFDR Tracking Number
M4-19-1724-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
November 26, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134. The carrier has not responded or denied this claim in its entirety following our filing of request for reconsideration."

Amount in Dispute: $576.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill for date of service 12/20/17 was denied based on extent/charge unrelated to the compensable injury. Carrier maintains the position that the provider is not entitled to reimbursement based on extent of injury. Furthermore, the provider did not timely appeal and therefore is not entitled to reimbursement."

Response Submitted by: ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 20, 2017	97799 MR	$576.00	$576.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 §134.240 sets out requirements for notification of payments or denials.
3. 28 Texas Administrative Code §134.204 sets out the reimbursement guidelines for specific workers

compensation services.
4. No explanation of benefits was submitted within the documents submitted to MFDR

Issues

1. Did the insurance carrier comply with DWC rules regarding explanation of benefits?
2. What rules is applicable to reimbursement?

Findings

1. The insurance carrier states in their position statement, "Carrier maintains the position that the provider is not entitled to reimbursement based on extent of injury."

   28 TAC §133.240 (a) and (b) (1) states in pertinent part,

   (a) An insurance carrier shall take final action after conducting bill review on a complete medical bill…not later than the 45th day after the insurance carrier received a complete medical bill…
   (e) The insurance carrier shall send the explanation of benefits in accordance with the elements required by §133.500 and §133.501 of this title…The explanation of benefits shall be sent to:
   (1) the health care provider when the insurance carrier makes payment or denies payment on a medical bill…

   The insurance Carrier's failure to timely issue an explanation of benefits to the health care provider creates a waiver of defenses that insurance carrier raised in its response to medical fee dispute resolution under 28 Texas Administrative Code §133.307(d)(2)(F):

   The carrier's response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review…

   Absent any evidence that insurance carrier raised defenses that conform with the requirements of Title 28, Part 2, Chapter 133, Subchapter C, the division concludes that the defenses presented in the insurance carrier's position statement shall not be considered for review because those assertions constitute new defenses pursuant to 28 Texas Administrative Code §133.307(d)(2)(F).

2. The requestor is seeking $576.00 for outpatient medical rehabilitation program services rendered December 20, 2017. 28 TAC 134.204 (h) (4) (A) (B) states in pertinent part,

   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.

   The submitted medical bill indicates:

   - Date of service December 20, 2017, 97799 -MR, 8 units, total charge $576.00

   Based on the applicable fee guideline $90 x 8 = $720.00. The requestor is seeking $576.00. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $576.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $576.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

_________________________	_________________________	December 20, 2018
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 in accordance with Rule §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 MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **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.