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
M4-19-2696-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JANUARY 15, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CPT code 97799 MR was preauthorized."

Amount in Dispute: $396.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Per Clinical Validation: DOS 02/01/18 $500.00 has been denied stating: Date(s) of service exceed time period for submission per Rule 133.250(b). DOS 02/05/2018 $350.00…(additional $36.00) was finalized in our system today and should be available…within 24-48 hours."

Response Submitted By: Gallagher Bassett Services

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 1, 2018 February 5, 2018	CPT Code 97799-MR	$396.00	$360.00

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, effective May 31, 2012 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 return to work rehabilitation programs.
3. 28 Texas Administrative Code §133.250, effective March 30, 2014 sets out the insurance carrier's medical bill process and reconsideration for payment of medical bills.

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.
   - P12, 223-Workers' compensation jurisdictional fee schedule adjustment.

- Z710-The charge for this procedure exceeds the fee schedule allowance.

Issues

1. What is the applicable fee guideline?
2. Is the respondent's denial of payment supported for services rendered on February 1, 2018?
3. Is the requestor entitled to additional reimbursement for services rendered on February 5, 2018?

Findings

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

2. The insurance carrier denied reimbursement for services rendered on February 1, 2018 based upon "112-Service not furnished directly to the patient and/or not documented." A review of the submitted medical report supports service; therefore, the insurance carrier's denial is not supported.

   The insurance carrier contends payment is not due because "Per the documentation received in this email, the carrier received 1/24/19. This would be over the 10 month timely filing allowance therefore it should be denied as the provider did not provide the required information within 10 months." The respondent also wrote "DCN 2018078GJ002287-Original submission. Only a copy of the bill was submitted."

   The following statute addresses issues raised in the respondent's position summary:

   - 28 Texas Administrative Code §133.250(b), "The health care provider shall submit the request for reconsideration no later than 10 months from the date of service."
   - 28 Texas Administrative Code §133.250(f) states, "An insurance carrier shall review all written reconsideration requests for completeness in accordance with subsection (d) of this section and may return an incomplete written reconsideration request no later than seven days from the date of receipt. A health care provider may complete and resubmit its written request to the insurance carrier."

   The division reviewed the submitted documentation and finds:

   - The requestor submitted a copy of a letter dated April 12, 2018 stamped Request for Reconsideration that states, "Enclosed are copies of the EOB and claim. The claim was denied per EOB service not furnished directly to the patient and/or not documented. CPT code 97799 MR was preauthorized…Please refer to your previous payments for further review."

   - The April 12, 2018 letter requesting reconsideration is within the 10 month deadline per 28 Texas Administrative Code §133.250(b).

   - No documentation from the respondent to support position that request for reconsideration was not received until January 24, 2019.

   - The respondent did not submit any documentation to support they returned the request for reconsideration for incompleteness per 28 Texas Administrative Code §133.250(f).

   The division finds the respondent did not support denial of payment; therefore, reimbursement is recommended.

   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 5 hours; therefore, 80% of $90.00 = $72.00 X 5 hours = $360.00. The respondent paid $0.00. The requestor is due the difference of $360.00.

3. The requestor billed $350.00 for services rendered on February 5, 2018. Based upon the submitted explanation of benefits, insurance carrier originally paid $216.00. The requestor is seeking additional reimbursement of $36.00.

   The respondent wrote, "(additional $36.00) was finalized in our system today and should be available…within 24-48 hours."

   The division finds the requestor has been paid in full for services rendered on February 5, 2018.

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 $360.00.

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 $360.00 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	3/8/2019 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.