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
IRVING ISD

MFDR Tracking Number
M4-20-2296-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
May 18, 2020

Response Submitted by:
IMO

REQUESTOR'S POSITION SUMMARY

"Work comp treatment and services no payment received."

RESPONDENT'S POSITION SUMMARY

"An PLN11 was filed by the carrier disputing …. No payments are being processed at this time."

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount in Dispute	Amount Due
July 9, 2019	97799-MR x 8 units	$576.00	$576.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code (TLC) §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §133.305 sets out the general guidelines for medical fee dispute resolution.
3. 28 TAC §133.240 sets out the guidelines designated doctor examination.
4. 28 TAC §134.230 sets out the fee guidelines for return to work rehabilitation programs.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 219 – Based on extent of injury

Issues

1. Is the insurance carrier's denial reason for extent of injury supported?
2. What is the fee guideline for CPT Code 97799-MR?
3. Is the requestor entitled to reimbursement?

Findings

1. The service in dispute was denied by the workers' compensation carrier due to an unresolved extent of injury issue. 28 TAC §133.305(b) states that if a dispute over the extent of a covered work injury exists for the same service for which there is a medical fee dispute, the dispute regarding the extent of injury shall be resolved prior to the submission of a medical fee dispute.

   Review of the documentation submitted by the parties finds that the carrier did not provided documentation to the DWC to support that it filed a Plain Language Notice (PLN) regarding the disputed conditions as required by 28 TAC §133.307(d)(2)(H). The respondent did not submit information to MFDR, sufficient to support that the PLN had been presented to the requestor or that the requestor had otherwise been informed of PLN prior to the date that the request for medical fee dispute resolution was filed with the Division; therefore, the division finds that the extent of injury denial was not timely presented to the requestor in the manner required by 28 TAC §133.240. Because the service in dispute does not contain an unresolved extent of injury issue, this matter is eligible for review pursuant to 28 TAC §133.307. For that reason, this matter is addressed pursuant to the applicable rules and guidelines.

2. The requestor billed CPT Code 97799-MR rendered on July 9, 2019. 28 TAC §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; and did not append a CA modifier, therefore, the disputed program is non-CARF accredited and reimbursement is at 80% of the MAR.

   28 TAC §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 unit's 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 8 hours; therefore, 80% of $90.00 = $72.00 X 8 hours = $576.00. The respondent paid $0.00. The requestor is therefore entitled to reimbursement in the amount of $576.00.

3. Review of the submitted documentation finds that the requestor is entitled to reimbursement in the amount of $576.00. Therefore, this amount is recommended.

Conclusion

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

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 $ 576.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		June 3, 2020
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 28 TAC §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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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 DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

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