TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
ERWIN A. CRUZ, MD

Respondent Name
TASB RISK MANAGEMENT FUND

MFDR Tracking Number
M4-21-1962-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
July 8, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 19, 2021	97799-MR	$576.00	$0.00
	Total	$576.00	$0.00

Requestor's Position

"Work Comp Treatment and Services no payment received."

Amount in Dispute: $576.00

Respondent's Position

"The Austin carrier representative for TASB Risk Management Fund is Burns Anderson Jury & Brenner. Burns Anderson Jury & Brenner was notified of this medical fee dispute on July 13, 2021. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information. As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1)."

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 §133.307, effective February 22, 2021 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §133.600 sets out the preauthorization guidelines for specific non-emergency services/procedures.
3. 28 TAC §134.203, sets out the reimbursement guidelines for return-to-work rehabilitation programs.

Denial Reasons

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:

- P12-Workers' compensation jurisdictional fee schedule adjustment.
- 320-non-accredited interdisciplinary program. Payment reduced 20% below MAR or 20% below usual and customary.
- 375-Please see special *NOTE* below-non-Cert.
- 350-Bill has been identified as a request for reconsideration or appeal [Reason]
- W3-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

Is the requestor entitled to additional reimbursement for CPT Code 97799-MR (x8) rendered on March 19, 2021?

Findings

The requestor is seeking medical fee dispute resolution in the amount of $576.00 for CPT Code 97799-MR (X8) rendered on March 19, 2021.

The respondent reduced payment for the disputed services based upon a lack of preauthorization. 28 TAC §134.600 (p) (10) requires preauthorization for 'chronic pain management/ interdisciplinary pain rehabilitation."

A review of the submitted documentation did not support that preauthorization was obtained for the dispute service; therefore, the respondent's denial is supported.

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 not established that reimbursement of $576.00 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to reimbursement for the disputed services.

Authorized Signature

		September 9, 2021
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 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 electronico CompConnection@tdi.texas.gov.