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
ERWIN CRUZ, MD

Respondent Name
TASB RISK MANAGEMENT FUND

MFDR Tracking Number
M4-21-1964-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
JULY 8, 2021

REQUESTOR'S POSITION SUMMARY

"The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134.."

Disputed Amount: $576.00

RESPONDENT'S POSITION SUMMARY

"The previous review is being maintained (Payment of $0) and no additional allowance is recommended as the services for 3/18/21 are Non-Certified."

Response Submitted by: TASB Risk Fund

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 18, 2021	CPT Code 97799-MR (X8) Outpatient Medical Rehabilitation Program	$576.00	$0.00

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 (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307, effective February 22, 2021 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.600, effective November 1, 2018, requires preauthorization for specific non-emergency services/procedures.
3. 28 TAC §134.230, effective July 17, 2016, sets out the reimbursement guidelines for return to work rehabilitation programs.
4. The services in dispute were reduced or denied payment based upon reason code(s):
    - P12-Workers' compensation jurisdictional fee schedule adjustment.
    - 30-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.

- 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 18, 2021?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $576.00 for CPT code 97799-MR (X8) rendered on March 18, 2021.

2. 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 preauthorization was obtained for the disputed service; therefore, the respondent's denial of payment is supported.

Conclusion

For the reasons stated above, the DWC finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the DWC has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		7/27/2021
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 in accordance with 28 Texas Administrative Code §133.307, 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 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 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 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