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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
NORTH TEXAS REHABILITATION CENTER

Respondent Name
ACE AMERICAN INSURANCE CO

MFDR Tracking Number
M4-20-2832-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
AUGUST 3, 2020

REQUESTOR'S POSITION SUMMARY

"Based on these claims we do not feel that these were processed correctly and need to be reviewed for payment. [Claimant] was approved by utilization review for an 'Interdisciplinary Traumatic Brain Injury Program' and participated. A fee schedule has not yet been determined for this type of treatment."

Amount in Dispute: $50,400.00

RESPONDENT'S POSITION SUMMARY

"ESIS Med Bill Impact's Bill Review Department reviewed the above mentioned date of service and found that the provider was not due additional money. It has been determined that ESIS Med Bill Impact will stand on the original recommendation of $0.00. Insufficient modifiers billed."

Response Submitted by: ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 16, 2020 through April 10, 2020	CPT Code 97799-CA Interdisciplinary Traumatic Brain Injury Program	$2,800.00/each date X 18 dates = $50,400.00	$50,400.00

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 May 31, 2012 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.230, effective July 7, 2016 sets out the fee guideline for return to work rehabilitation programs.
3. 28 TAC §134.1, provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code (TLC) §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 402- The appropriate modifier was not utilized.
   - 4-The procedure code is inconsistent with the modifier used or a required modifier is missing.
   - CIQ378-This appeal is denied as we find the original review reflected the appropriate allowance for the service rendered. We find that no additional recommendation is warranted at this time.
   - 18-Duplicate claim/service.
   - 072-We are in receipt of your appeal that has been submitted and replied to more than once. This denial is our final response, unless additional information that would altar our decision is submitted in the future.
   - 148-This procedure on this date was previously reviewed.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Is the requestor entitled to reimbursement for an Interdisciplinary Traumatic Brain Injury Program rendered from March 16, 2020 through April 10, 2020?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $50,400.00 for an Interdisciplinary Traumatic Brain Injury Program rendered from March 16, 2020 through April 10, 2020.
2. On March 12, 2020, the respondent gave preauthorization approval for Brain Injury Program, 20 sessions, 5Xweek for 4 weeks.
3. The requestor billed for the Interdisciplinary Traumatic Brain Injury Program with CPT code 97799-CA. 97799 is defined as “Unlisted physical medicine/rehabilitation service or procedure.” The requestor appended modifier “CA.”
4. To determine if the disputed services are eligible for reimbursement the DWC refers to the following statute:

   - TLC §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

   - 28 TAC §134.1(e)(3) states, “Medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with: (3) in the absence of an applicable fee guideline or a negotiated contract, a fair and reasonable reimbursement amount as specified in subsection (f) of this section.”

   - 28 TAC §134.1(f) states, “Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.”

   - 28 TAC §134.230 states, “The following shall be applied to Return To Work Rehabilitation Programs for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a division Return to Work Rehabilitation Program, a program should meet the specific program standards for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual, which includes active

participation in recovery and return to work planning by the injured employee, employer and payor or insurance carrier."

- 28 TAC §134.230 states, "(1) 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).
- 28 TAC §133.307(c)(2)(O) requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the DWC has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable."

5. Review of the submitted documentation finds that:

- The requestor asks to be reimbursed the full amount of the billed charges because "A fee schedule has not yet been determined for this type of treatment."
- The respondent issued payment of $0.00 for the disputed services based upon a modifier was missing.
- 28 TAC §134.230 does not apply to Interdisciplinary Traumatic Brain Injury Programs; therefore, the respondent's denial based upon a modifier missing is not supported.
- The DWC has not established a fee guideline for Traumatic Brain Injury Programs.
- The requestor submitted redacted copies of EOBs from ten different insurance carriers that support payment of $2800.00.
- The DWC finds that most insurance carriers found $2800.00 to be fair and reasonable reimbursement.
- The requestor submitted copies of EOBs from ESIS that support payment of $2360.00 and $2240.00 were made for similar services based upon a negotiated contract or the fee guideline.
- The DWC finds the requested amount to be consistent with TLC §413.011(d).
- The requestor supported that payment of the requested amount would satisfy the requirements of 28 TAC §134.1.

Conclusion

North Texas Rehabilitation Center met its burden to prove that the amount of payment it seeks from Ace American Insurance Co is fair and reasonable. Consequently, North Texas Rehabilitation Center's request for reimbursement of $50,400.00 is recommended.

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 $50,400.00, 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	11/18/2020 Date
Signature	Director of Medical Fee Dispute Resolution	November 18, 2020 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.