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
NORTH TEXAS REHABILITATION

Respondent Name
WC SOLUTIONS

MFDR Tracking Number
M4-21-1024-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
February 22, 2021

Response Submitted by:
Flahive, Ogden & Latson

REQUESTOR'S POSITION SUMMARY

"We pre-authorized a "Brain Injury Program" and per the TDI Guidelines a fee schedule has not been determined for this type of treatment nor, has a modifier been assigned. This is a complex program and continues to need constant supervision from multiple providers. At this time, we are asking that these claims be sent back for Reprocessing for an agreed fair and reasonable rate based on §134.203."

RESPONDENT'S POSITION SUMMARY

"The provider's CMS-1500s identified the number of units as '1'. A review of the provider's documents suggest that the provider was providing 6 hours of services per day for each of the dates of service in question. The carrier reimbursed the provider at $125 per hour based upon CPT code 97799. See Division rule 134.230 (5) which covers a chronic pain management program under CPT code 97799. The reimbursement rate is $125 per hour if the provider is CARF accredited. At 6 hours per day, the reimbursement rate is a total of $750 per day which is what the provider has been paid."

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount in Dispute	Amount Due
February 7, 2020, through April 22, 2020	97799-CA Interdisciplinary Traumatic Brain Injury Program	$43,250.00	$8,200.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code (TLC) §413.031 and applicable 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 §134.1 sets out the fair and reasonable reimbursement guidelines in the absence of an applicable fee guideline.
3. 28 TAC §133.30 sets out the Telemedicine and Telehealth Services.
4. Texas Labor Code (TLC) §413.011 sets forth provisions regarding reimbursement policies and guidelines
5. 28 TAC §134.203, effective March 1, 2008, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system.

6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - W3 – RECONSIDERATION.
   - 193 - ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - 1241 - NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION/REQUEST FOR SECOND REVIEW.
   - 6000 - REQUEST FOR RECONSIDERATION.
   - P12 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 1001 - BASED ON THE CORRECTED BILLJNG AND/OR ADDITIONAL INFORMATION/DOCUMENTATION NOW SUBMITTED BY THE PROVIDER, WE ARE RECOMMENDING FURTHER PAYMENT TO BE MADE FDR THE ABOVE NOTED PROCEDURE.

Issue(s)

1. Did the requestor waive the right to medical fee dispute resolution for dates of service February 7, 2020, through February 21, 2020?
2. Is the requestor entitled to additional reimbursement for an Interdisciplinary Traumatic Brain Injury Program rendered at North Texas Pain Recovery Center on March 3, 2020, through March 11, 2020?
3. Is the requestor entitled to reimbursement for an Interdisciplinary Traumatic Brain Injury Program billed as telemedicine services and rendered on March 30, 2020, through April 22, 2020?

Findings

1. The requestor seeks additional reimbursement for Interdisciplinary Traumatic Brain Injury Program rendered on February 7, 2020, through April 22, 2020.

   28 TAC §133.307(c) (1) states in pertinent part, "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute."

   The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on February 22, 2021. The dates of the services in dispute include February 7, 2020, through February 21, 2020. These dates are later than one year from the receipt date. Review of the submitted documentation finds that the disputed services do not involve issues identified in 28 TAC §133.307(c) (1) (B). The Division concludes that the requestor has failed to timely file dates of service February 7, 2020, through February 21, 2020, with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution for these dates of service.

2. The requestor seeks additional reimbursement in the amount of $8,200.00 for a preauthorized Interdisciplinary Traumatic Brain Injury Program rendered on March 3, 2020, through March 11, 2020, and provided at the facility, North Texas Rehabilitation Center.

   The division has not established a medical fee guideline for an Interdisciplinary Traumatic Brain Injury Program. Review of the submitted information finds no documentation to support a negotiated contract or that the services were provided through a workers' compensation health care network. Payment is therefore subject to the general medical reimbursement provisions of 28 Texas Administrative Code §134.1(e), which requires that, in the absence of an applicable fee guideline or a negotiated contract, medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with a fair and reasonable reimbursement amount as specified in Rule §134.1(f).

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."

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 payments totaling $3,000.00 for dates of service March 3, 2020, through March 11, 2020.
- The respondent seeks an additional payment amount of $8,200.00 for dates of service March 3, 2020, through March 11, 2020.
- The DWC has not established a fee guideline for Traumatic Brain Injury Programs.
- The requestor submitted redacted copies of EOBs from several 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 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.

The DWC finds that the requestor sufficiently supported that additional reimbursement in the amount of $8,200 is due for dates of service March 3, 2020, through March 11, 2020, is due. As a result, this amount is recommended.

3. The requestor seeks reimbursement in the amount of $20,700 for an Interdisciplinary Traumatic Brain Injury Program rendered on March 30, 2020, through April 22, 2020, and billed as telemedicine services.

   The requestor billed for the Interdisciplinary Traumatic Brain Injury Program with CPT code 97799. CPT Code 97799 is defined as "Unlisted physical medicine/rehabilitation service or procedure."

   The requestor appended modifier "CA" to identify that the services are CARF accredited.

   The requestor also appended modifier "95" and place of service code "02" to identify that the services were provided as telehealth services.

   Per 28 TAC §133.30 a health care provider may bill and be reimbursed for telemedicine and telehealth services regardless of the geographical area or location of the injured employee. Telehealth and telemedicine services are billed as professional services. Reimbursement for professional services is established by the Medical Fee Guideline for Professional Services, 28 TAC §134.203.

   28 TAC §134.203(b)(1) states in part "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   The DWC now considers whether the disputed services are covered telemedicine or telehealth services. Review of the Medicare Covered Telehealth services at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes, found that the disputed service, CPT Code 97799 is not a CPT Code listed in the covered telehealth code list. As DWC follows Medicare guidelines and the disputed services are not on the Medicare covered list, the disputed services are not eligible for reimbursement.

   The DWC finds that the respondent's denial is supported, and the requestor is therefore not entitled to reimbursement for CPT Code 97799-CA-95 rendered on March 30, 2020, through April 22, 2020.

Conclusion

North Texas Rehabilitation Center met its burden to prove that the amount of payment it seeks from WC Solutions is fair and reasonable. Therefore, North Texas Rehabilitation Center's request for reimbursement of $8,200 for dates of service March 3, 2020, through March 11, 2020, is recommended.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of TLC Sections 413.031 and 413.019 (if applicable), the DWC has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The DWC hereby ORDERS the respondent to remit to the requestor the amount of $8,200.00 plus applicable accrued interest per 28 TAC §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 10, 2021 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, 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 TAC §141.1(d).

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