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 CENTER

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-21-1645-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
May 14, 2021

Response Submitted by:
Texas Mutual Insurance Company

REQUESTOR'S POSITION SUMMARY

"I have submitted reconsiderations to Texas Mutual along with the guidelines pertaining to telamed [sic] during the COVID pandemic. I have been denied after submitting all the information. There is also a letter of negotiation on this patients account for this specialty program. If you should have any question regarding this matter, please contact me…"

RESPONDENT'S POSITION SUMMARY

"Texas Mutual denied the requestor's bills for telemedicine with place of service code 11 for in the office. However, Texas Mutual also denied the bills because CPT 97799 is not included in the service allowed under Medicare telehealth billing codes. Texas Mutual maintained this denial even after the requestor corrected the place of service code. Therefore, Texas Mutual is entitled to a decision in its favor."

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount in Dispute	Amount Due
May 18, 2020, through June 18, 2020	97799-CA Interdisciplinary Traumatic Brain Injury Program	$50,400.00	$0.00

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 §133.30 sets out the Telemedicine and Telehealth Services.
3. Texas Labor Code (TLC) §413.011 sets forth provisions regarding reimbursement policies and guidelines
4. 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.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 892 – DWC telemedicine/telehealth requires use of POS 02
   - 892-97799 is not allowed under CMS telemedicine and telehealth billing code.
   - CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
   - 225 – The submitted documentation does not support the service being billed. We will re-evaluated this upon receipt of clarifying information.
   - 892 – denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions.

Issue(s)

Is the insurance carrier's reduction of payment supported for the Interdisciplinary Traumatic Brain Injury Program rendered on May 18, 2020, through June 18, 2020?

Findings

The requestor seeks reimbursement in the amount of $50,400.00 for an Interdisciplinary Traumatic Brain Injury Program rendered on May 18, 2020, through June 18, 2020. 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 respondent denied these services with reason code "892-97799 is not allowed under CMS telemedicine and telehealth billing code."

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 reason is supported, and the requestor is therefore not entitled to reimbursement for CPT Code 97799-CA-95 rendered on May 18, 2020, through June 18, 2020.

Conclusion

In resolving disputes over reimbursement, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision, are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered. For the reasons above the requestor has established that reimbursement cannot be recommended for the services in dispute. 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 TLC §413.031, the DWC has determined that the requestor is not entitled to reimbursement for the disputed services.

Authorized Signature

		June 10, 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 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.